# North Carolina Department of Health and Human Services
## Division of Mental Health, Developmental Disabilities and Substance Abuse Services

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Michael F. Easley, Governor
Carmen Hooker Odom, Secretary

Michael Moseley, Director


August 23, 2004

**MEMORANDUM**

**TO:** Legislative Oversight Committee Members
MH/DD/SAS Commission
Consumer/Family Advisory Committee Chairs
Advocacy Organizations and Groups
North Carolina Association of County Commissioners
County Managers
County Manager Chairs
North Carolina Council of Community Programs
Area Program Directors
Area Program Board Chairs
Provider Organizations
DHHS Division Directors
DMH/DD/SAS Institution Directors
MH/DD/SAS Professional Organizations and Groups
MH/DD/SAS Stakeholder Organizations and Groups
Other MH/DD/SAS Stakeholders

**From**: Mike Moseley

**RE: Communication Bulletin #026**
Draft 1915 (c ) Home and Community Based Waiver


Attached is the draft of the comprehensive 1915 (c ) Home and Community Based Waiver. This draft is simultaneously being submitted to the Division of Medical Assistance and posted to the Division of MH/DD/SAS public website. It should be noted that the Quality Management Plan is in the process of reorganization to insure clarity in addressing the components of the Centers for Medicaid and Medicare (CMS) Quality Framework and will be posted to the web once this is completed.

Effective this date there will be a 30-day comment period ending on September 23, 2004. Comments may be submitted by email, fax or written communication. Due to resource, time and efficiency problems, feedback will not be responded to on an individual basis. Comments should be directed to:


Steve Hairston, Team Leader
Planning Team
DMH/DD/SAS
3003 Mail Service Center
Raleigh, NC 27699-3003
Email: Steven.Hairston@ncmail.net

As the second phase in the waiver development process, the DMH/DD/SAS Waiver Workgroup will begin work in September toward an application for an Independence Plus waiver which will provide the option of self-directed supports. A completion date of June 30, 2005 is projected.

Cc: Secretary Carmen Hooker Odom
Lanier Cansler
James Bernstein
Robin Huffman
Bob Hedrick
Kaye Holder
DMH Staff
Rich Slipsky
DMH/DD/SAS Executive Leadership Team
Carol Robertson
Carol Duncan Clayton
Mike Mayer
Patrice Roesler
Dick Oliver
Jim Klingler
Rob Lamme

# SECTION 1915(c) WAIVER FORMAT

1. The State of **North Carolina** requests a Medicaid home and community-based services waiver under the authority of section 1915(c) of the Social Security Act. The administrative authority under which this waiver will be operated is contained in Appendix A.

   This is a request for a model waiver.

   a.____ Yes  b.__**X**__ No

   If yes, the State assures that no more than 200 individuals will be served by this waiver at any one time.

   This waiver is requested for a period of (check one):

   a.__**X**__ 3 years (initial waiver)

   b.____ 5 years (renewal waiver)

2. This waiver is requested in order to provide home and community-based services to individuals who, but for the provision of such services, would require the following levels (s) of care, the cost of which could be reimbursed under the approved Medicaid State plan:

   a.____ Nursing facility (NF)

   b.__**X**__ Intermediate care facility for mentally retarded or persons with related conditions (ICF/MR)

   c.____ Hospital

   d.____ NF (served in hospital)

   e. ICF/MR (served in hospital)

3. A waiver of section 1902(a)(10)(B) of the Act is requested to target waiver services to one of the select group(s) of individuals who would be otherwise eligible for waiver services:

   a.____ Aged (age 65 and older)

   b.____ Disabled

c.____ Aged and Disabled

d.____ Mentally Retarded

e.____ Developmentally Disabled

f.__**X**__ Mentally Retarded and Developmentally Disabled

g.____ Chronically Mentally Ill

4. A waiver of section 1902(a)(10)(B) of the act is also requested to impose the following additional targeting restrictions (specify):

a.____ Waiver services are limited to the following age groups (specify):

b.____ Waiver services are limited to individuals with the following disease(s) or condition(s) (specify):

c.____ Waiver services are limited to individuals who are mentally retarded or developmentally disabled, who currently reside in general NFs, but who have been shown, as a result of the Pre-Admission Screening and Annual Resident Review process mandated by P.L. 100-203 to require active treatment at the level of an ICF/MR.

d.____ Other criteria. (Specify):

e.__**X**__ Not applicable.

5. Except as specified in item 6 below, an individual must meet the Medicaid eligibility criteria set forth in Appendix C-1 in addition to meeting the targeting criteria in items 2 through 4 of this request.

6. This waiver program includes individuals who are eligible under medically needy groups.

a.__**X**__ Yes b.____ No

7. A waiver of 1902(a)(10)(C)(i)(III) of the Social Security Act has been requested in order to use institutional income and resource rules for the medically needy.

a. **X** Yes b.____ No c.____ N/A

8. The State will refuse to offer home and community-based services to any person for whom it can reasonably be expected that the cost of home or community-based services furnished to that individual would exceed the cost of a level of care referred to in item 2 of this request.

a.____ Yes b. **X** No

**Through the implementation of aggregate funding versus slot funding individuals will receive the waiver funding that they need. Waiver funding does not replace other informal or formal supports that are available to the individual.**

9. A waiver of the "state wideness" requirements set forth in section 1902(a)(1) of the Act is requested.

a. **X** Yes b.____ No

If yes, waiver services will be furnished only to individuals in the following geographic areas or political subdivisions of the State (Specify):

**Upon CMS approval of the Piedmont Innovations 1915C Home and Community Based Waiver, this Waiver will serve individuals who are legal residents of all North Carolina counties except for those who reside in the following North Carolina counties: Cabarrus, Davidson, Rowan, Stanly, and Union counties. The Piedmont Innovations Waiver will serve individuals in these five counties. For the purpose of these Waivers, Medicaid eligibility is defined as the individual's county of Medicaid eligibility.**

10. A waiver of the amount, duration and scope of services requirements contained in section 1902(a)(10)(B) of the Act is requested, in order that services not otherwise available under the approved Medicaid State plan may be provided to individuals served on the waiver.

11. The State requests that the following home and community-based services, as described and defined in Appendix B.1 of this request, be included under this waiver:

a.____ Case management

b.____ Homemaker

c.____ Home health aide services

d. **X** Personal care services

e. **X** Respite care

f. **X** Adult day health

g. **X** Habilitation

**X** Residential Habilitation **(Renamed Residential Supports)**

**X** Day Habilitation **(Renamed Day Supports)**

_____ Prevocational services

**X** Supported employment services

_____ Educational services

**X** **Home and Community Supports**

h. **X** Environmental accessibility adaptations **(Renamed Home Modifications)**

i. ____ Skilled nursing

j. **X** Transportation

k. **X** Specialized medical equipment and supplies **(Renamed Specialized Equipment and Supplies)**

l._____ Chore services

m. **X** Personal Emergency Response Systems

n.____ Companion services

o.____ Private duty nursing

p. **X** Family training **(Renamed Individual/Caregiver Training and Education)**

q._____ Attendant care

r.____ Adult Residential Care

____ Adult foster care

____ Assisted living

s.____ Extended State plan services (Check all that apply):

____ Physician services

____ Home health care services

____ Physical therapy services

____ Occupational therapy services

____ Speech, hearing and language services

____ Prescribed drugs

____ Other (specify):

t.__**X**__ Other services (specify): **Augmentative Communication, Crisis Services, Vehicle Adaptations, and Specialized Consultation Services.**

u. _____The following services will be provided to individuals with chronic mental illness:

____ Day treatment/Partial hospitalization

____ Psychosocial rehabilitation

____ Clinic services (whether or not furnished in a facility)

12. The state assures that adequate standards exist for each provider of services under the waiver. The State further assures that all provider standards will be met.

13. An individual written plan of care will be developed by qualified individuals for each individual under this waiver. This plan of care will describe the medical and other services (regardless of funding source) to be furnished, their frequency, and the type of provider who will furnish each. All services will be furnished pursuant to a written plan of care. The plan of care will be subject to the approval of the Medicaid agency. FFP will not be claimed for waiver services furnished prior to the development of the plan of care. FFP will not be claimed for waiver services, which are not included in the individual written plan of care.

14. Waiver services will not be furnished to individuals who are inpatients of a hospital, NF, or ICF/MR.

15. FFP will not be claimed in expenditures for the cost of room and board, with the following exception(s) (Check all that apply):

a. **X** When provided as part of respite care in a facility approved by the State that is not a private residence (hospital, nursing facility, foster home, or community residential facility).

b. ____ Meals furnished as part of a program of adult day health services.

c. ____ When a live-in personal caregiver (who is unrelated to the individual receiving care) provides approved waiver services, a portion of the rent and food that may be reasonably attributed to the caregiver who resides in the same household with the waiver recipient. FFP for rent and food for a live-in caregiver is not available if the recipient lives in the caregiver's home, or in a residence that is owned or leased by the provider of Medicaid services. An explanation of the method by which room and board costs are computed is included in Appendix G-3.

For purposes of this provision, "board" means 3 meals a day, or any other full nutritional regimen.

16. The Medicaid agency provides the following assurances to CMS:

a. Necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. Those safeguards include:

1. Adequate standards for all types of providers that furnish services under the waiver (see Appendix B),

2. Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver (see Appendix B). The State assures that these requirements will be met on the date that the services are furnished; and

3. Assurance that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

b. The agency will provide for an evaluation (and periodic reevaluations, at least annually) of the need for a level of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future (one month or less), but

for the availability of home and community-based services. The requirements for such evaluations and reevaluations are detailed in Appendix D.

c. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, and is included in the targeting criteria included in items 3 and 4 of this request, the individual or his or her legal representative will be:

1. Informed of any feasible alternatives under the waiver; and

2. Given the choice of either institutional or home and community-based services.

d. The agency will provide an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to persons who are not given the choice of home or community-based services as an alternative to institutional care indicated in item 2 of this request, or who are denied the service(s) of their choice, or the provider(s) of their choice.

e. The average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures for the level(s) of care indicated in item 2 of this request under the State plan that would have been made in that fiscal year had the waiver not been granted.

f. The agency's actual total expenditure for home and community-based and other Medicaid services under the waiver and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred by the State's Medicaid program for these individuals in the institutional setting(s) indicated in item 2 of this request in the absence of the waiver.

g. Absent the waiver, persons served in the waiver would receive the appropriate type of Medicaid-funded institutional care that they require, as indicated in item 2 of this request.

h. The agency will provide CMS annually with information on the impact of the waiver on the type, amount and cost of services provided under the State plan and on the health and welfare of the persons served on the waiver. The information will be consistent with a data collection plan designed by CMS.

i. The agency will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver program (except as CMS may otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.

The State conducts a single audit in conformance with the Single Audit Act of 1984, P.L. 98-502.

a. **X** Yes b. ____ No

17. The State will provide for an independent assessment of its waiver that evaluates the quality of care provided, access to care, and cost-neutrality. The results of the assessment will be submitted to CMS at least 90 days prior to the expiration of the approved waiver period and cover the first 24 months (new waivers) or 48 months (renewal waivers) of the waiver.

    a. ____ Yes b. **X** No

18. The State assures that it will have in place a formal system by which it ensures the health and welfare of the individuals served on the waiver, through monitoring of the quality control procedures described in this waiver document (including Appendices). Monitoring will ensure that all provider standards and health and welfare assurances are continuously met, and that plans of care are periodically reviewed to ensure that the services furnished are consistent with the identified needs of the individuals. Through these procedures, the State will ensure the quality of services furnished under the waiver and the State plan to waiver persons served on the waiver. The State further assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the severity and nature of the deficiencies.

19. An effective date of **April 1, 2005** is requested.

20. The State contact person for this request is **Carol Robertson**, who can be reached by telephone at **(919) 857-4031**.

    **Carol Robertson, DMA Behavioral Healthcare Manager**
    **North Carolina Division of Medical Assistance**
    **2501 Mail Service Center**
    **Raleigh, NC 27699-2501**

    **E-Mail:** Carol.Robertson@ncmail.net

21. This document, together with Appendices A through G, and all attachments, constitutes the State's request for a home and community-based service waiver under section 1915(c) of the Social Security Act. The State affirms that it will abide by all terms and conditions set forth in the waiver (including Appendices and attachments), and certifies that any modifications to the waiver request will be submitted in writing by the State Medicaid agency. Upon approval by CMS, this waiver request will serve as the State's authority to provide home and community services to the target group under its Medicaid plan. Any proposed changes to the approved waiver will be formally requested by the State in the form of waiver amendments.

The State assures that all material referenced in this waiver application (including standards, licensure and certification requirements) will be kept on file at the Medicaid agency.

Signature:

Print Name: **Gary H. Fuquay**

Title: **Director, North Carolina Division of Medical Assistance**

Date:

## APPENDIX A - ADMINISTRATION

LINE OF AUTHORITY FOR WAIVER OPERATION

CHECK ONE:

____ The waiver will be operated directly by the Medical Assistance Unit of the Medicaid agency.

____ The waiver will be operated by _____, a separate agency of the State, under the supervision of the Medicaid agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.

__**X**__ The waiver will be operated by **DMH/DD/SAS*,** a separate division within the Single State agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.

*** DMH/DD/SAS = Division of Mental Health/Developmental Disabilities/and Substance Abuse Services. See also Appendix A (1)**

## APPENDIX A(1) ADMINISTRATION

**Administration:**

**The North Carolina Division of Mental Health/Developmental Disabilities/Substance Abuse Services (DMH/DD/SAS) is the Lead Agency for statewide operations of this Waiver. The North Carolina Division of Medical Assistance oversees the overall operation of the Waiver according to federal and state guidelines. The Divisions cooperate in the operation of the Waiver under a Memorandum of Understanding that delineates each Division's responsibilities.**

**The North Carolina General Assembly, in session Law 2001-437, designated the local mental health authorities as the "locus of coordination" for the provision of all publicly funded MH/DD/SA services. The local mental health authorities are known as Local Management Entities (LME) *. Local Management Entities are the local lead agencies for the day to day operations of the waiver in the counties they serve. LMEs assure that the policies and procedures for all the programs in the public mental health, developmental disabilities and substance abuse services system are followed, including waiver services. They are responsible for the health, safety and welfare of individuals receiving services, for assuring integrity of the provision of services and supports with the service plan/Plan of Care, and for assuring that individuals receive the appropriate level of care (ICF-MR for waiver services).**

**LMEs are provided a global waiver "virtual budget" (allocation) by DMH/DD/SAS along with an expectation that a minimum number of individuals be enrolled in the waiver each year. The waiver funds are referred to as a "virtual budget" because no money actually transfers to the LMEs' accounts for expenditures. Reimbursement for waiver services is paid directly to service providers by the Medicaid agency upon the submission of clean billing claims.**

**The allocation is based on the historical and projected cost of waiver participants within the LME. LMEs are required to establish internal reporting mechanisms to track use of waiver funds. DMH/DD/SAS monitors the status of the LMEs virtual budgets by using information from the Medicaid Paid Claims Information System. State information is shared with LMEs on a monthly basis.**

**DMH/DD/SAS and DMA jointly ensure that the actual total expenditure for home and community-based and other Medicaid services under the waiver and the claim for FFP in expenditures for the services provided to individuals under the waiver do not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred by the State's Medicaid program for these individuals in the ICF-MR institutional settings.**

***The term Local Management Entities (LMEs) refers also to and is inclusive of Area Authorities and County Programs.**

**Plan of Care Approval Process:**

**The Division of Medical Assistance (DMA) authorizes an LME, or other designated Lead Agency, to approve waiver plans. The Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) initiates this process. DMH/DD/SAS sends a written request to the DMA Waiver Manager that describes the respective LME's or designated Lead Agency's capacity to approve waiver plans. The request describes the process and addresses proficiency in the plan approval procedures, including position(s) responsible for making approval decisions. After receiving all required information, the DMA Waiver Manager promptly reviews the recommendation and responds in writing to DMH/DD/SAS. DMH/DD/SAS notifies the LME or designated Lead Agency of the decision.**

**DMA monitors the plan of care approval process through monthly quality assurance activities as required by the waiver. DMH/DD/SAS also conducts routine monitoring of the plan of care approval process. DMA and DMH/DD/SAS share results of the monitoring activities and initiate corrective action as needed. DMA may revoke approval authority if it determines that the LME or designated Lead Agency is not in compliance with waiver requirements. In the case of a revocation, the plan of care approval responsibility and authority is reassigned by DMH/DD/SAS with approval by DMA in accordance with G.S. 122C-125.1. Refer to Attachment to Appendix A page 14.**

**Utilization Review:**

**Lead Agencies must adhere to standardized, statewide Utilization Review criteria and process established by the Division of MH/DD/SAS, and approved by the Division of Medical Assistance, in addition to the family or person-centered planning process, in order to insure that services authorized meet the needs of the individual. Utilization Review will include criteria for state level reviews. Upon CMS approval of the Piedmont Innovations 1915C Home and Community Based Waiver, the Utilization Review criteria will not apply to the counties under Piedmont Local Management Entity. These include Cabarrus, Davidson, Rowan, Stanly, and Union counties.**

**North Carolina Mental Health,**
**Developmental Disabilities,**
**And**
**Substance Abuse**

**General Statute**

## 122C-125.1. Area Authority failure to provide services; State assumption of service delivery.

**Statute text:**

At any time that the Secretary determines that an area authority is not providing minimally adequate services, in accordance with its annual service plan, to persons in need in a timely manner, or fails to demonstrate reasonable efforts to do so, the Secretary, after providing written notification of the Secretary's intent to the area board and providing the area authority an opportunity to be heard, may assume control of the particular service in questions or of the area authority and appoint an administrator to exercise the powers assumed. The assumption of control shall have the effect of divesting the area authority or its powers in G.S. 122C-117 and all other service delivery powers conferred in the area authority by law as they pertain to this service. County funding of the area authority shall continue when the State has assumed control of a service area or of the area authority. At no time after the State has assumed this control shall a county withdraw funds previously obligated or appropriated to the area authority. Upon assumption of control of service delivery, the Department shall, in conjunction with the area authority, develop and implement a corrective plan of action and provide notification to the area authority's board of directors of the plan. The Department shall also keep the county board of commissioners and the area authority's board of directors informed of any ongoing concerns or problems with the area authority's delivery of services. (Reg. Sess., 1996), c. 749, s. 8.)

## APPENDIX B - SERVICES AND STANDARDS

### APPENDIX B-1: DEFINITION OF SERVICES

The State requests that the following home and community-based services, as described and defined herein, be included under this waiver. Provider qualifications/standards for each service are set forth in Appendix B-2.

**In all cases, services under this waiver are secondary to services available under the State Plan under Title XIX. If the services and supports needed by a waiver recipient are reimbursable under the State Plan, the State Plan services shall be authorized; waiver services shall only be authorized when the services and supports needed are not reimbursable under the State Plan.**

**In accordance with 42 CFR 431.62, waiver services to be delivered out of state are subject to the same requirements as services delivered out of state under the State Plan.**

a. ____ Case Management: **Targeted Case management services will be provided to individuals participating in this waiver through the State Medicaid Plan. Provider Agencies, including their subsidiary corporations, related partners, or closely allied entities, may not provide Targeted Case Management Services and Waiver Services to the same person.**

___ Services, which will assist individuals who receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained.

Case managers shall be responsible for ongoing monitoring of the provision of services included in the individual's plan of care.

1. **X** Yes 2. ___ No

Case managers shall initiate and oversee the process of assessment and reassessment of the individual's level of care and the review of plans of care at such intervals as are specified in Appendices C & D of this request.

1. **X** Yes 2. No_____

_____ Other Service Definition (Specify):

b. ____ Homemaker:

___ Services consisting of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to

manage the home and care for him or herself or others in the home. Homemakers shall meet such standards of education and training as are established by the State for the provision of these activities.

___ Other Service Definition (Specify):

c.___ Home Health Aide services:

___ Services defined in 42 CFR 440.70, with the exception that limitations on the amount, duration and scope of such services imposed by the State's approved Medicaid plan shall not be applicable. The amount, duration and scope of these services shall instead be in accordance with the estimates given in Appendix G of this waiver request. Services provided under the waiver shall be in addition to any available under the approved State plan.

____ Other Service Definition (Specify):

d. _**X**_ Personal Care Services:

___ Assistance with eating, bathing, dressing, personal hygiene, activities of daily living. These services may include assistance with preparation of meals, but does not include the cost of the meals themselves. When specified in the plan of care, this service may also include such housekeeping chores as bed making, dusting and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the individual, rather than the individual's family. Personal care providers must meet State standards for this service.

1. Services provided by family members (Check one):

___ Payment will not be made for personal care services furnished by a member of the individual's family.

__X__ Personal care providers may be members of the individual's family. Payment will not be made for services furnished to a minor by the child's parent (or step-parent), legal guardian of minor, or to an individual by that person's spouse.

Justification attached. (Check one):

__X__ Family members who provide personal care services must meet the same standards as providers who are unrelated to the individual.

___ Standards for family members providing personal care services differ from those for other providers of this service. The different standards are indicated in Appendix B-2.

2. Supervision of personal care providers will be furnished by (Check all that apply):

__X__ A registered nurse, licensed to practice nursing in the State.

___ A licensed practical or vocational nurse, under the supervision of a registered nurse, as provided under State law.

___ Case managers

__X__ Other (Specify): **A Qualified Professional or Associate Professional when provided by an LME or certified Private Provider Agency as specified in Appendix B-2.**

3. Frequency or intensity of supervision (Check one):

__X__ As indicated in the plan of care

___ Other (Specify):

4. Relationship to State plan services (Check one):

___ Personal care services are not provided under the approved State plan.

___ Personal care services are included in the State plan, but with limitations. The waiver service will serve as an

extension of the State plan service, in accordance with documentation provided in Appendix G of this waiver request.

__X__ Personal care services under the State plan differ in service definition or provider type from the services to be offered under the waiver.

__X__ Other service definition (Specify):

**Personal Care Services include support, supervision and engaging participation with eating, bathing, dressing, personal hygiene and other activities of daily living. Support and engaging consumer participation describes the flexibility of activities that may encourage the person to maintain skills gained during active treatment and/or habilitation while also providing supervision for independent activities of the consumer. This service may include assistance with preparation of meals, but does not include the cost of the meals themselves. When specified in the plan of care, this service may also include such housekeeping chores as bed making, dusting and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the individual, rather than the individual's family. Personal Care also includes assistance with monitoring health status and physical condition, assistance with transferring, ambulation and use of special mobility devices.**

**This service also provides assistance in the workplace with activities not already required or funded by other sources or services, including travel assistance.**

**Service Limitations:**

- **This service does not include medical transportation and may not be provided during medical transportation and medical appointments; and**
- **Individuals who live in licensed residential facilities, licensed alternative family living homes, licensed foster care homes or unlicensed alternative family living homes serving one adult may not receive this service**

e. __X__ Respite Care:

___ Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.

__X__ Other service definition (Specify):

**Respite Care is a service that provides periodic relief for the family or primary caregiver. In order to be considered the primary care giver, a person must be principally responsible for the care and supervision of the individual, and must maintain their primary residence at the same address as the covered individual. This service may be provided in the individual's home or in an out-of-home setting.**

**Service Limitations:**

- **Private home respite services serving individuals outside their private homes are subject to licensure under G.S. 122C Article 2 when:**
    1. **more than two individuals are served concurrently, or**
    2. **either one of two children, two adults, or any combination thereof are served for a cumulative period to time exceeding 240 hours per calendar month;**
- **Respite service may not be used as a daily service;**
- **Respite services may not be provided for individuals living in licensed group homes or adult care homes;**
- **Respite services may not be used for individuals who are living alone or with a roommate;**
- **Staff sleep time is not reimbursable;**
- **Respite Care services are only provided for the individual; other family members, such as siblings of the individual and may not receive care from the provider while Respite Care is being provided/billed for the individual;**
- **Respite Care is not provided by any individual who resides in the individual's primary place of residence;**
- **The cost of 24 hours of respite care cannot exceed the per diem rate for the average community ICF-MR Facility; and**
- **FFP will not be claimed for the cost of room and board except when provided, as part of respite care furnished in a facility approved by the State that is not a private residence.**

Respite Care will be provided in the following location(s) (Check all that apply):

__X__ Individual's home or place of residence

__X__ Foster home

___ Medicaid certified Hospital

___ Medicaid certified NF

___ Medicaid certified ICF/MR

___ Group home

__X__ Licensed respite care facility

__X__ Other community care residential facility approved by the State that is not a private residence (Specify type):

- **Alternative Family Living**
- **Certified respite provider's home**
- **State Regional Mental Retardation Facility**

f. __X__ Adult day health:

___ Services furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the individual. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day). Physical, occupational and speech therapies indicated in the individual's plan of care will be furnished as component parts of this service.

Transportation between the individual's place of residence and the adult day health center will be provided as a component part of adult day health services. The cost of this transportation is included in the rate paid to providers of adult day health services. (Check one):

1.___Yes 2.___No

__X__ Other service definition (Specify):

**Adult Day Health Services is a service furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the individual. Meals provided as part of these services shall not constitute a "full nutritional regiment" (3 meals per day). Services are provided in a certified Adult Day Health Care facility. This service is for adults who are aged, disabled, and handicapped that need a structured day program of activities and services with nursing supervision. It is an organized program of services during the day in a community group setting for the purpose of supporting an adult's independence, and promoting social, physical, and emotional well-being. Services must include health services and a variety of program activities designed to meet the individual needs and interests.**

The cost of this transportation is included in the rate paid to providers of adult day health services. (Check one):

1.___ Yes 2.__X__ No

g.__X__ Habilitation:

__X__ Services designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. This service includes:

__X__ Residential habilitation: **Renamed: Residential Supports**

**Residential Supports** provide assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting. **Habilitation, training and instruction are coupled with elements of support, supervision and engaging participation to reflect the natural flow of training, practice of skills, and other activities as they occur during the course of the person's day. This service is distinctive in that it includes active treatment, habilitation and training activities. Interactions with the person are designed to achieve outcomes identified in the Plan of Care. Support and supervision of the person's activities to sustain skills gained through habilitation and training is also an acceptable goal of Residential Supports.**

**This service is provided to individuals who live in licensed community residential settings, foster homes, or alternative family living homes as well as unlicensed alternative family living homes that serve one adult. This service also provides assistance, support, supervision, and monitoring that allow individuals to participate in home or community activities.**

**Service Limitations:**

- **Payments for residential habilitation are not made for room and board;**
- **Payment for residential habilitation does not include payments made, directly or indirectly, to members of the individual's immediate family;**
- **Payments will not be made for the routine care and supervision that would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid. Documentation that shows that Medicaid payment does not cover these components is attached to Appendix G.**
- **Residential Supports can be provided in licensed residential settings of 8 beds or less including licensed Alternative Family Living or Foster Homes and unlicensed alternative family living homes serving one adult. Individuals who live in licensed group homes or adult care homes with more than 8 beds and who were participating in the CAP-MR/DD Waiver (North Carolina's approved 1915-C Home and Community Based Waiver) at the time of the implementation of this Waiver may also receive Residential Supports; and**
- **Individuals who receive Residential Supports may not receive State Plan Adult Care Personal Care Services or waiver Personal Care Services;**

____**X**__(Day habilitation) Renamed: **Day Supports**

**Day Supports** provide assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which take place in a non-residential setting, separate from the home or facility in which the individual resides.

**Day Supports** shall focus on enabling the individual to attain or maintain his or her maximum functional level and shall be

coordinated with any physical, occupational, or speech therapies listed in the plan of care. In addition, habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings

**Community Activities that originate from a licensed day facility will be provided and billed as Day Supports. On site attendance at the licensed facility is not required to receive services that originate from the facility.**

**Service Limitation:**

**This service may only be provided by a licensed day facility.**

___ Prevocational services not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)). Services are aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Prevocational services are provided to persons not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs).

Prevocational services are available only to individuals who have previously been discharged from a SNF, ICF, NF or ICF/MR.

Check one:

___ Individuals will not be compensated for prevocational services.

___ When compensated, individuals are paid at less than 50 percent of the minimum wage.

Activities included in this service are not primarily directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills. All prevocational services will be reflected in the individual's plan of care as directed to habilitative, rather than explicit employment objectives.

Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and

2. The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

___ Educational services, which consist of special education and related services as defined in section s (15) and (17) of the Individuals with Disabilities Education Act, to the extent to which they are not available under a program funded by IDEA. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and

2. The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

__**X**__ Supported employment services, which consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting.

Supported employment is conducted in a variety of settings; particularly work sites in which persons without disabilities are employed. Supported employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training.

When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

Supported employment services furnished under the waiver are not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142. Documentation will be maintained in the file of each individual receiving this service that:

- The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142.

FFP will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

2. Payments that are passed through to users of supported employment programs; or

3. Payments for vocational training that is not directly related to an individual's supported employment program.

Transportation will be provided between the individual's place of residence and the site of the habilitation services, or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation services.

1. X Yes 2. ___ No

**Service Limitation:**

**Supported Employment must be reviewed every six months by the LME with continuing authorization contingent upon achievement of outcomes in the individual's Plan of Care.**

**X** Other service definition (Specify): **Home and Community Supports**

**Home and Community Supports services provide instruction and assistance to enable the individual to acquire and maintain skills that will allow him/her to function with greater independence in the community. Home and Community Supports provides habilitation, training and instruction coupled with elements of support, supervision and engaging participation to reflect the natural flow of training, practice of skills, and other activities as they occur during the course of the person's day. Interactions with the person are designed to achieve outcomes identified in the Plan of Care. Support and supervision of the person's activities to sustain skills gained through habilitation and training is also an acceptable goal of Home and Community Supports. This service may be provided in an individual's private residence and/or in the community.**

**Home and Community Supports consist of an integrated array of individually designed services and supports that are described in the Plan of Care. This service is distinctive from Personal Care Services by the presence of training activities in addition to support, supervision, and monitoring as described in the Plan of Care.**

**Home and Community Supports include:**

- **Training and/or support with socialization that includes**

**development or maintenance of self-awareness and self-control, social responsiveness, social amenities, and interpersonal skills, and the development and maintenance of personal relationships,**

- **Training and/or support with personal skill development that includes activities designated to improve the participants' own ability to accomplish every day activities of community living, including eating, bathing, dressing, personal hygiene, and mobility; and**
- **Training and support with community participation, recreation, or leisure that includes the development or maintenance of skills to use community resources, facilities or businesses and support in accessing such opportunities for community integration.**

**Service Limitations:**

- **Payments will not be made for the routine care and supervision that is expected to be provided by an Alternative Family Living or Group Home provider or for supervision for which payment is made by a source other than Medicaid.**
- **Individuals who live in group homes may only receive the community component of this service.**

The State requests the authority to provide the following additional services, not specified in the statute. The State assures that each service is cost-effective and necessary to prevent institutionalization. The cost neutrality of each service is demonstrated in Appendix G. Qualifications of providers are found in Appendix B-2.

h. **X** Environmental accessibility adaptations:

___ Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual.

Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations that add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

X Other service definition (Specify): **(Renamed Home Modifications)**

**Home Modifications are equipment and physical adaptations to the individual's home which are required by his/her needs as documented in the Plan of Care, as necessary to ensure the health, safety and welfare of the person; enable the person to function with greater independence in the home; and are of direct and specific benefit due to the person's disability. Home Modifications are cost effective compared to the provision of other services that would be required in an inaccessible environment. The service will reimburse the purchase, installation, maintenance and repair of Home Modifications. Repairs are covered when the cost is efficient compared to the cost of the replacement of the item only after coverage of the warranty is explored.**

**Home Modifications will only be provided when the modification is necessary to meet the needs of the person and prevents institutionalization. All services shall be provided in accordance with State or Local Building Codes.**

**Home Modifications include:**

- **Installation, maintenance and repairs of ramps and grab bars and handrails as well as portable ramps;**
- **Widening of doorways/passageways for handicap accessibility;**
- **Modification of bathroom facilities including handicap toilet, shower/tub modified for physically involved persons, sink modifications, toilet modifications, water faucet controls, floor urinal adaptations, plumbing modifications, and turnaround space modifications;**
- **Bedroom modifications to accommodate hospital beds and/or wheelchairs;**
- **Thermostats, shelves, closets, sinks, counters , cabinets and doorknobs;**
- **Shatterproof windows;**
- **Floor coverings for ease of ambulation;**
- **Modifications to meet egress regulations;**
- **Alarm systems/alert systems including auditory, vibratory, and visual to ensure the health, safety, and welfare of the person (includes signaling devices for persons with hearing and vision loss);**
- **Fences to ensure the health, safety and welfare of an ambulatory waiver recipient who lives in a private home and does not receive paid supervision for 10 hours per day or more;**
- **Video cameras to ensure the health, safety, and welfare of a wavier recipient who must be visually monitored while sleeping for medical reasons, and who resides in a private home without paid supervision during sleep hours;**
- **Porch or stair lifts;**
- **Hydraulic, manual, or electronic lifts, including portable lifts or**

**lift systems which could be removed and taken to a new location that are used inside the individual's home;**

- **Stationary/built in therapeutic table;**
- **Weather protective modifications; and**
- **Fire safety adaptations;**

**Service Limitations:**

- **Modifications that add to the total square footage of the home are excluded from this benefit;**
- **Home Modifications can only be provided in the following settings:**
  1. **Dwellings where the waiver recipient resides that is owned by the individual or the family or;**
  2. **In rented residences when the modifications are portable**
- **This service cannot be used to purchase locks; and**
- **The total cost of Home Modifications cannot exceed $15,000 over the duration of this Waiver (3 years).**

i.___ Skilled nursing:

___ Services listed in the plan of care which are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State.

___ Other service definition (Specify):

j. **X** Transportation:

**X** Service offered in order to enable individuals served on the waiver to gain access to waiver and other community services, activities and resources, specified by the plan of care. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. Transportation services under the waiver shall be offered in accordance with the individual's plan of care.

Whenever possible, family, neighbors, friends, or community agencies, which can provide this service without charge, will be utilized.

Additional Medicaid payment will not be provided to provider agencies to provide transportation to and/or from the person's residence and the site of a habilitation service when payment is included in the established rate paid to the provider.

Service Limitation:

Transportation Services are limited to $1,200.00 per waiver year per person.

___ Other service definition (Specify):

k. **X** Specialized Medical Equipment and Supplies:

___ Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items and durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items, which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation.

X Other service definition (Specify): **(Renamed Specialized Equipment and Supplies):**

**Specialized Equipment and Supplies include devices, controls, or appliances specified in the person's Plan of Care that enables the person to increase the ability to perform activities of daily living, or to perceive, control or communicate with the environment in which they live. Items under this service shall be directly attributable to the person's ability to avoid being institutionalized and shall exclude those items which are not of direct benefit to the person. All items shall meet applicable standards of manufacture, design and installation.**

**The service includes the following categories of items:**

***Category 1:*** **Adaptive Positioning Devices – standers, trays and attachments, prone boards and attachments, positioning chairs and sitters, multi-function physiosystem, bolster rolls and wedges, motor activity shapes, therapeutic balls, visualizer ball, physio- roll, therapy mats when used in conjunction with adaptive positioning devices.**

***Category 2:*** **Mobility Aids – walkers, attachments, and accessories, swivel wheeled scoot-about, adaptive car seats for physically involved individuals, customized/specialized wheelchairs, strollers, accessories and parts for adults, repair of specialized/customized wheelchairs for adults, splints/orthotics for adults (including replacement materials and repairs), prosthetic/orthopedic shoes and devices for adults, protective helmets that are medically necessary for adults, specialized adaptive tricycles to improve the person's gross motor skills.**

***Category 3:*** **Aids for Daily Living – adaptive eating utensils (cups/mugs; spoons, forks, knives, universal gripping aid for utensils, adjustable universal utensil cuff, utensil holder, non-skid inner lip plate, sloping, deep plates, scooper, plate guards, non-skid pads for plate/bowl, wheelchair cup holders); adaptive eating equipment; adaptive, assistive devices/aids including adaptive switches and attachments; mobile and/or adjustable**
**tables and trays for chairs, wheelchairs, and beds; adaptive**

**toothbrushes; universal holder accessories for dressing, grooming, and hygiene; toilet trainer with anterior and lateral supports; adaptive toileting chairs and bath chairs and accessories not on the State DME list: adaptive hygiene/dressing aids, adaptive clothing, non-disposable clothing protectors; reusable incontinence garments with disposable liners for individuals age two and above; dietary scales, food/fluid thickeners for dysphasia treatment; that are supplements covered by Medicaid for Home Infusion Therapy/Tube feedings; bed rails, assistive listening devices for individuals with hearing and vision loss (TDD, large visual display devices, Braille screen communicators FM systems, volume control large print telephones, teletouch systems); medication dispensing boxes.**

l.___ Chore services:

___ Services needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access and egress. These services will be provided only in cases where neither the individual, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payer is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

___ Other service definition (Specify):

m.__X__ Personal Emergency Response Systems (PERS)

__X__ PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified in Appendix B-2. PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, who are alone for any period of time and have a written plan for increasing the duration of time spent alone as a means of gaining a greater level of independence, or who have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

___ Other service definition (Specify):

n.___ Adult companion services:

___ Non-medical care, supervision and socialization, provided to a functionally impaired adult. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks which are incidental to the care and supervision of the individual. This service is provided in accordance with a therapeutic goal in the plan of care, and is not purely diversional in nature.

___ Other service definition (Specify):

o.___ Private duty nursing:

___ Individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within the scope of State law. These services are provided to an individual at home.

___ Other service definition (Specify):

p. **X** Family training:

___ Training and counseling services for the families of individuals served on this waiver. For purposes of this service, "family" is defined as the persons who lives with or provides care to a person served on the waiver, and may include a parent, spouse, children, relatives, foster family, or in-laws. "Family" does not include individuals who are employed to care for the consumer. Training includes instruction about treatment regimens and use of equipment specified in the plan of care, and shall include updates as necessary to safely maintain the individual at home. All family training must be included in the individual's written plan of care.

**X** Other service definition (Specify): **(Renamed Individual/Caregiver Training and Education):**

**Individual/Caregiver Training and Education includes training and counseling services for the individual and or family members of the individual. The purpose of this service is to enhance the decision making capacity of the family unit, provide orientation regarding the nature and impact of the developmental disability upon the individual and his/her family, provide information about community integration options and strategies, provide education and training on intervention strategies, and provide education and training on the use of specialized equipment and supplies. Updates are included to maintain the person safely at home. For purpose of this service "family" is defined as the people who live with or provide care to the person receiving waiver services, and may include a parent, spouse, children, relatives, foster family, guardians or in-laws. "Family" does not include individuals who are employed to care for**

**the person. All family training will include outcomes that are documented in the person's Plan of Care. The service includes conference registration, travel to conferences, and enrollment fees for classes.**

**Service Limitations:**

- **Individual/Caregiver Training and Education excludes training furnished to family members though Specialized Consultative Services;**
- **The service is limited to a maximum expenditure of $1500 per waiver year per person which includes a maximum of $1000 for conference registration, travel to conferences, and enrollment fees for classes, and**
- **Individuals who are paid service providers are excluded from this service.**

q.___ Attendant care services:

___ Hands-on care, of both a supportive and health-related nature, specific to the needs of a medically stable, physically handicapped individual. Supportive services are those which substitute for the absence, loss, diminution, or impairment of a physical or cognitive function. This service may include skilled or nursing care to the extent permitted by State law. Housekeeping activities which are incidental to the performance of care may also be furnished as part of this activity.

Supervision (Check all that apply):

___ Supervision will be provided by a Registered Nurse, licensed to practice in the State. The frequency and intensity of supervision will be specified in the individual's written plan of care.

___ Supervision may be furnished directly by the individual, when the person has been trained to perform this function, and when the safety and efficacy of consumer-provided supervision has been certified in writing by a registered nurse or otherwise as provided in State law. This certification must be based on direct observation of the consumer and the specific attendant care provider, during the actual provision of care. Documentation of this certification will be maintained in the consumer's individual plan of care.

___ Other supervisory arrangements (Specify):

___ Other service definition (Specify):

r.___ Adult Residential Care (Check all that apply):

___ Adult foster care: Personal care and services, homemaker, chore, attendant care and companion services medication oversight (to the extent permitted

under State law) provided in a licensed (where applicable) private home by a principal care provider who lives in the home. Adult foster care is furnished to adults who receive these services in conjunction with residing in the home.

The total number of individuals (including persons served in the waiver) living in the home, who are unrelated to the principal care provider, cannot exceed). Separate payment will not be made for homemaker or chore services furnished to an individual receiving adult foster care services, since these services are integral to and inherent in the provision of adult foster care services.

___ Assisted living: Personal care and services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under State law), therapeutic social and recreational programming, provided in a home-like environment in a licensed (where applicable) community care facility, in conjunction with residing in the facility. This service includes 24-hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security.

Other individuals or agencies may also furnish care directly, or under arrangement with the community care facility, but the care provided by these other entities supplements that provided by the community care facility and does not supplant it.

Personalized care is furnished to individuals who reside in their own living units (which may include dually occupied units when both occupants consent to the arrangement) which may or may not include kitchenette and/or living rooms and which contain bedrooms and toilet facilities. The consumer has a right to privacy. Living units may be locked at the discretion of the consumer, except when a physician or mental health professional has certified in writing that the consumer is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. (This requirement does not apply where it conflicts with fire code.) Each living unit is separate and distinct from each other.

The facility must have a central dining room, living room or parlor, and common activity center(s) (which may also serve as living rooms or dining rooms).

The consumer retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. Care must be furnished in a way, which fosters the independence of each consumer to facilitate aging in place.

Routines of care provision and service delivery must be consumer-driven to the maximum extent possible, and treat each person with dignity and respect.

Assisted living services may also include (Check all that apply):

___ Home health care

___ Physical therapy

___ Occupational therapy

___ Speech therapy

___ Medication administration

___ Intermittent skilled nursing services

___ Transportation specified in the plan of care

___ Periodic nursing evaluations

___ Other (Specify)

However, nursing and skilled therapy services (except periodic nursing evaluations if specified above) are incidental, rather than integral to the provision of assisted living services. Payment will not be made for 24-hour skilled care or supervision. FFP is not available in the cost of room and board furnished in conjunction with residing in an assisted living facility.

___ Other service definition (Specify):

Payments for adult residential care services are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. Payment for adult residential care services does not include payments made, directly or indirectly, to members of the consumer's immediate family. The methodology by which payments are calculated and made is described in Appendix G.

**_X_** Other waiver services which are cost-effective and necessary to prevent institutionalization (Specify): **Augmentative Communication; Crisis Services; Specialized Consultative Services and Vehicle Adaptations.**

**Augmentative Communication:**

**Augmentative Communication devices are necessary when normal speech is non-functional and/or when physical impairments make a gestural system impossible and/or ineffective. An aided system requires access to a symbolic system that is separate from the body. Selection of devices (and training outcomes for those devices) must be specific and based on age, cognitive ability, fine and gross mobility, environmental need and presence or absence of sensory impairment. These devices are recommended by a speech/language pathologist licensed to practice in the State of**

**North Carolina and documented in the Plan of Care as necessary to meet the needs of the individual. The Plan also specifies who and how the individual and/or his/her family/caregiver will be trained on the use of the equipment.**

**This service also covers technical assistance provided to individuals in the selection of augmentative communication devices by qualified augmentative communication technology professionals. This assistance may not duplicate evaluation and services provided by licensed speech, occupational, and/or physical therapists.**

**The hardware and software needed to augment communication is divided into the following categories:**

- **Low Technology and Clinician Made Devices**
- **High Technology, commercially available Dedicated Devices and Systems**
- **Standard Computer/Monitors and operating peripherals**
- **Computer-Driven devices, operating peripherals and printers**
- **Mounting kits and accessories for each component**
- **Overlay Kits and accessories**
- **Switches/Pointers/Access Equipment—all types, Standard and Specialized**
- **Keyboard/Voice Emulators/Key guards**
- **Voice Synthesizers**
- **Carry Cases**
- **Supplies (battery, battery charger)**
- **Artificial Larynges**

**Service Limitations:**

- **The cost of Augmentative Communication Devices shall not exceed $10,000 per waiver year per person,**
- **Augmentative Communicative devices cannot be purchased for use in the school system, and**
- **The service may not be used to purchase cameras.**

**Crisis Services:**

**Crisis Services provide one additional staff support person for supervision for the person as needed during an acute crisis situation so that the person can continue to participate in his/her daily routine and/or residential setting without interruption. It is appropriate to provide such support during periods of time in which the person is presenting episodes of unmanageable and/or inappropriate behaviors that require specialized staff intervention. An individual may display extreme, maladaptive behaviors that are not anticipated, are temporary in nature, and are beyond the daily behaviors that are addressed through other supports. Crises of this nature may be due to medication changes, reaction to family stress, or other trauma. By**

**providing this service, an imminent institutional admission may be avoided while protecting the person from harming themselves(s) or others.**

**While receiving this service, the person is able to remain in his/her place of residence, in the day program, or in respite care, while a crisis plan is developed and implemented. Crisis Services staff will implement intervention plans that are directed at reducing the maladaptive behavior. This service is only offered in the setting(s) where the person receives services.**

**Crisis Services is provided for periods of up to 14 consecutive days per episode. An initial order for the service may be approved by the case manager with approval or denial of the service authorization by the Local Management Entity/Area Authority/County Program within 3 days of service inception. Following any first use of Crisis Stabilization, the individual's Plan of Care will be reviewed and updated to reflect a plan for prevention and interventions of subsequent occurrences. The Plan of Care must identify crisis early warning signals, triggers, and the necessary services and supports to insure the health and safety of the individual. Any plan that involves the use of restrictive interventions will be written by a psychologist or psychiatrist and approved by the Client Rights Committee.**

**Service Limitations:**

- **An individual may not receive over 2,016 hours per waiver year per person.**

**Specialized Consultative Services:**

**Specialized Consultative Services provides expertise, training, and technical assistance in a specialty area (psychology, behavioral analysis, therapeutic recreation, speech therapy, occupational therapy, physical therapy, or nutrition) to assist family members, caregivers, and other direct service employees in supporting individuals with developmental disabilities who have long term habilitative treatment needs. Under this model, family members and other paid/unpaid caregivers are trained by a licensed professional to carry out therapeutic interventions, which will provide consistency, therefore increasing the effectiveness of the specialized therapy. This service will also be utilized to allow specialists as defined to be an integral part of the treatment team by participating in team meetings and providing additional intensive consultation and support for individuals whose medical and/or behavioral psychiatric needs are considered to be extreme or complex. The need for Specialized Consultative Services must be clearly reflected on the individual's Plan of Care.**

**The activities below are *not* covered under the State Medicaid Plan but are covered under Specialized Consultative Services. These Activities take place with and without the person being present. These activities will be observed on at least a quarterly basis:**

- **Observing the individual prior to the development/revision of the Support Plan to assess and determine treatment needs and the effectiveness of current interventions/support techniques.**
- **Constructing a written Support Plan to clearly delineate the interventions and activities to**

**be carried out by family members, caregivers, and program staff. The Support Plan details strategies, responsibilities, and expected outcomes.**

- **Training relevant persons to implement the specific interventions/supports/techniques delineated in the Support Plan and to observe the person, to record data, and to monitor implementation of therapeutic interventions/support strategies.**
- **Reviewing documentation and evaluating the activities conducted by the family members, caregivers, or program staff as delineated in the Support Plan with revision of that Plan as needed to assure continued relevance and progress toward achievement of outcomes.**
- **Training and technical assistance to family members, caregivers, and other individuals primarily responsible for carrying out the person's Plan of Care on the specific interventions/activities, delineated in the Support Plan, outcomes expected and review procedures.**
- **Participating in treatment team meetings.**

**Service Limitations:**

- **This service may not duplicate services provided to family members through Individual/ Caregiver Training and Education; and**
- **The total cost reimburseable under the Waiver will not exceed $1500 per person per Waiver Year.**

**Vehicle Adaptations:**

**Vehicle Adaptations are provided if, on an individual basis, the cost effectiveness of vehicle adaptations, relative to alternative transportation services is established. Vehicle adaptations are devices, controls, or services that enable individuals to increase their independence and/or physical safety. The repair, maintenance, installation, and training in the care and use of these items are included. Vehicle adaptations, repairs, and maintenance of equipment shall be performed by the adaptive equipment manufacturer's authorized dealer according to manufacturer's installation instructions, and National Mobility Equipment Dealers' Association, Society of Automotive Engineers, and National Highway and Traffic Safety Administration guidelines. When appropriate, waiver recipients are referred to Vocational Rehabilitation Services to acquire vehicle adaptation consultation services.**

**The following types of adaptations to the vehicles are allowed:**

- **Door handle replacements,**
- **Door modifications,**
- **Installation of a raised roof or related alterations to existing raised roof systems to improve head clearance,**
- **Lifting devices,**
- **Devices for securing wheelchairs or scooters,**
- **Devices for transporting wheelchairs or scooters,**
- **Adapted steering, acceleration, signaling, and braking devices only when recommended by a physician and a certified driving evaluator for people with disabilities, and when training in the installed device is provided by certified personnel,**

- **Seating Modifications,**
- **Safety/security modifications,**
- **Handrails and grab bars, and/or**
- **Lowering of the floor of the vehicle.**

**Service Limitations:**

- **Alterations to vehicles are limited to vehicles, owned by the individual, or the individual's family. Family does not include vehicles owned by staff of licensed facilities, including non-licensed Alternative Family Living homes of one adult or licensed Alternative Family Living/Foster homes for children or adults, including guardians in those settings,**
- **The adaptations do not include the purchase price of the vehicle itself,**
- **The cost of Vehicle Adaptations shall not exceed $15,000 over the duration of the waiver (three years).**

t.___ Extended State plan services:

The following services, available through the approved State plan, will be provided, except that the limitations on amount, duration and scope specified in the plan will not apply. Services will be as defined and described in the approved State plan. The provider qualifications listed in the plan will apply, and are hereby incorporated into this waiver request by reference. These services will be provided under the State plan until the plan limitations have been reached.

Documentation of the extent of services and cost-effectiveness are demonstrated in Appendix G. (Check all that apply):

___ Physician services

___ Home health care services

___ Physical therapy services

___ Occupational therapy services

___ Speech, hearing and language services

___ Prescribed drugs

___ Other State plan services (Specify):

u.___ Services for individuals with chronic mental illness, consisting of (Check one):

___ Day treatment or other partial hospitalization services (Check one):

___ Services that are necessary for the diagnosis or treatment of the individual's mental illness. These services consist of the following elements:

a. individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law),

b. occupational therapy, requiring the skills of a qualified occupational therapist,

c. services of social workers, trained psychiatric nurses, and other staff trained to work with individuals with psychiatric illness,

d. drugs and biologicals furnished for therapeutic purposes,

e. individual activity therapies that are not primarily recreational or diversionary,

f. family counseling (the primary purpose of which is treatment of the individual's condition),

g. training and education of the individual (to the extent that training and educational activities are closely and clearly related to the individual's care and treatment), and

h. diagnostic services.

Meals and transportation are excluded from reimbursement under this service. The purpose of this service is to maintain the individual's condition and functional level and to prevent relapse or hospitalization.

___ Other service definition (Specify):

___ Psychosocial rehabilitation services (Check one):

___ Medical or remedial services recommended by a physician or other licensed practitioner under State law, for the maximum reduction of physical or mental disability and the restoration of maximum functional level.

Specific psychosocial rehabilitation services include the

following:

a. restoration and maintenance of daily living skills (grooming, personal hygiene, cooking, nutrition, health and mental health education, medication management, money management and maintenance of the living environment);

b. social skills training in appropriate use of community services;

c. development of appropriate personal support networks, therapeutic recreational services (which are focused on therapeutic intervention, rather than diversion); and

d. telephone monitoring and counseling services.

The following are specifically excluded from Medicaid payment for psychosocial rehabilitation services:

a. vocational services,

b. prevocational services,

c. supported employment services, and

d. room and board.

___ Other service definition (Specify):

___ Clinic services (whether or not furnished in a facility) are services defined in 42 CFR 440.90.

Check one:

___ This service is furnished only on the premises of a clinic.

___ Clinic services provided under this waiver may be furnished outside the clinic facility. Services may be furnished in the following locations (Specify):

**APPENDIX B-2**

PROVIDER QUALIFICATIONS

A. LICENSURE AND CERTIFICATION CHART

The following chart indicates the requirements for the provision of each service under the waiver. Licensure, Regulation, State Administrative Codes are referenced by citation. Standards not addressed under uniform State citation are attached.

NCAC= North Carolina Administrative Code, GS= General Statute, APSM= Administrative Procedures and Standards Manual

| SERVICE | PROVIDER | LICENSE | CERTIFICATION | OTHER STANDARD |
|---|---|---|---|---|
| Personal Care | Provider Agency/Organization<br><br>Local Management Entity (LME)<br><br>Home Care Agency | Licensed by the Division of Facility Services (DFS) as a Home Care Agency | Providers Agencies/ Organizations are certified by the LME<br><br>LMEs are approved by DHHS | Worker Qualifications: must meet requirements for paraprofessional in 10A NCAC 27G .0100-.0200. Client specific competencies to be met as identified by the individual's person centered planning team and documented in the plan of care. Direct care staff must have a criminal record check. A healthcare registry check is required in accordance with 10A NCAC 27G.0200. Driving record must be checked if providing transportation.<br><br>**Staff providing enhanced personal care have additional training/instruction specific to the medical and/or behavioral needs of the consumer.** |

| SERVICE | PROVIDER | LICENSE | CERTIFICATION | OTHER STANDARD |
|---|---|---|---|---|
| Respite | Provider Agency/Organization<br><br>Local Management Entity (LME) | As applicable, licensed by DFS as a respite care facility in accordance with G.S. 122C | Providers Agencies/ Organizations are certified by LMEs<br><br>LMEs are approved by DHHS | Worker Qualifications: must meet requirements for paraprofessional in 10A NCAC 27G .0100-.0200. Client specific competencies to be met as identified by the individual's person centered planning team and documented in the plan of care. Direct care staff must have a criminal record check. A healthcare registry check is required in accordance with 10A NCAC 27G.0200. Driving record must be checked if providing transportation.<br><br>**Staff providing enhanced respite care have additional training/instruction specific to the medical and/or behavioral needs of the consumer.** |
| Respite-Institutional | State regional MR facility | | Certified by DFS as an ICF-MR in accordance with federal conditions of participation | State MRCs have deemed status for all training and documentation requirements.<br>This type of respite must be provided in a Medicaid ICF-MR bed in a State regional mental retardation facility. |
| Respite Nursing | Provider Agency/ Organization<br><br>Local Management Entity (LME) | | Providers Agencies/ Organizations are certified by the LME<br><br>LMEs are approved by DHHS | Worker Qualifications: RN or LPN<br><br>Service providers must have a criminal record check and healthcare registry check. Driving record must by checked if providing transportation. |

| SERVICE | PROVIDER | LICENSE | CERTIFICATION | OTHER STANDARD |
|---|---|---|---|---|
| Home and Community Support (HCS) | Provider Agency/Organization<br><br>Local Management Entity (LME) | | Providers Agencies/ Organizations are certified by the LME<br><br>LMEs are approved by DHHS | Worker Qualifications: must meet requirements for paraprofessional in 10A NCAC 27G .0100-.0200. Client specific competencies to be met as identified by the individual's person centered planning team and documented in the plan of care. Direct care staff must have a criminal record check. A healthcare registry check is required in accordance with 10A NCAC 27G.0200. Driving record must be checked if providing transportation. |
| Residential Supports | Provider Agency/Organization<br><br>Local Management Entity (LME) | | Providers Agencies/ Organizations are certified by LME/ Area Authorities/County Programs<br><br>LMEs are approved by DHHS | Worker Qualifications: must meet requirements for paraprofessional in 10A NCAC 27G .0100-.0200. Client specific competencies to be met as identified by the individual's person centered planning team and documented in the plan of care. Direct care staff must have a criminal record check. A healthcare registry check is required in accordance with 10A NCAC 27G.0200. Driving record must be checked if providing transportation. |

| SERVICE | PROVIDER | LICENSE | CERTIFICATION | OTHER STANDARD |
|---|---|---|---|---|
| Day Supports | Provider Agency/Organization | 10A NCAC 27G as applicable | Providers Agencies/ Organizations are certified by the LME | Worker Qualifications: must meet requirements for paraprofessional in 10A NCAC 27G .0100-.0200. Client specific competencies to be met as identified by the individual's person centered planning team and documented in the plan of care. Direct care staff must have a criminal record check. A healthcare registry check is required in accordance with 10A NCAC 27G.0200. Driving record must be checked if providing transportation. |
| | Local Management Entity (LME) | | LMEs are approved by DHHS | |
| | Licensed Developmental Day Programs | Licensed Developmental Day Programs - .2200-.2400 | Licensed Developmental Day Programs -license approved by the Division of Child and Maternal Health | Licensed Developmental Day Programs - trained individual with at least a high school diploma or high school equivalency supervised by a Qualified Professional or Associate Professional |
| | Licensed Day Care Programs | Licensed Day Care Programs - GS 110 Article 7 | Licensed Day Care Programs - Private Providers are certified by LME | Licensed Day Care Programs - general and license requirements only |
| | Adult Day Care Programs | Adult Day Care Programs | Adult Day Care and Adult Day Health Programs -Certified as Adult Day Care or Adult Day Health Facility by Division of Aging | Adult Day Health and Adult Day Care Programs - general and certification requirements only |
| | Before and After School Day Care Programs operated by NC Public School System | | Before and After School Day Care Programs operated by NC Public School System and qualified by LMEs | Before and After School Day Care Programs operated by NC Public School System-qualified by the LME- general and license requirements only |

| SERVICE | PROVIDER | LICENSE | CERTIFICATION | OTHER STANDARD |
|---|---|---|---|---|
| Supported Employment | Provider Agency/ Organization<br><br>Local Management Entity (LME) | | Providers Agencies/ Organizations are certified by LME/ Area Authorities/County Programs<br><br>LMEs are approved by DHHS | Worker Qualifications: must meet requirements for paraprofessional in 10A NCAC 27G .0100-.0200. Client specific competencies to be met as identified by the individual's person centered planning team and documented in the plan of care. Direct care staff must have a criminal record check. A healthcare registry check is required in accordance with 10A NCAC 27G.0200. Driving record must be checked if providing transportation. |
| Home Modifications | Local Management Entity (LME) | | LMEs are approved by DHHS | Must meet applicable state and local building codes. Purchasing follows LME business procedures. |
| Specialized Consultative Services | Provider Agency/Organization<br><br>Local Management Entity (LME) | | Providers Agencies/ Organizations are certified by LME<br><br>LMEs are approved by DHHS | Worker Qualifications: Must hold appropriate NC license for PT, OT, ST, psychology, nutrition; or state certification for Recreation Therapy. |
| Transportation | Local Management Entity (LME) | | LMEs are approved by DHHS | Insurance coverage as required by NC law, driving record check and criminal background checks. |
| Specialized Equipment and Supplies | Local Management Entity (LME) | | LMEs are approved by DHHS | Purchasing follows LME business procedures. |
| Augmentative Communication | Local Management Entity (LME | | LMEs are approved by DHHS | Purchasing follows LME business procedures. Augmentative Communication Devices must be recommended by speech/language pathologist licensed to practice in NC. |
| Personal Emergency Response System | PERS Agency | Business license | | Must be able to provide 24/hour service. |

| SERVICE | PROVIDER | LICENSE | CERTIFICATION | OTHER STANDARD |
|---|---|---|---|---|
| Individual/ Caregiver Training and Education | Provider Agency/Organization<br><br>Local Management Entity (LME) | | Providers Agencies/ Organizations are certified by LME<br><br>LMEs are approved by DHHS | Worker Qualifications: Must have expertise as appropriate, in the field in which the training is being provided. Driving record must be checked if providing transportation. |
| Crisis Services | Provider Agency/Organization<br><br>Local Management Entity (LME | | Providers Agencies/ Organizations are certified by LME<br><br>LMEs are approved by DHHS | Worker Qualifications: must meet requirements for paraprofessional in 10A NCAC 27G .0100-.0200. Client specific competencies to be met as identified by the individual's person centered planning team and documented in the plan of care. Direct care staff must have a criminal record check. A healthcare registry check is required in accordance with 10A NCAC 27G.0200. Driving record must be checked if providing transportation. |
| Vehicle Adaptation | Local Management Entity (LME) | | | Must meet safety codes if applicable to the modification being provided. |
| Adult Day Health | Adult Day Health Care Facility | | Certified by the NC Division of Aging | Adult Day Health and Adult Day Care Programs - general and certification requirements only |

**Note:** Wavier services cannot be provided to recipients by legally responsible relatives, i.e., spouse or parents/step-parents, guardians of minor children when the services are those that these persons are already legally obligated to provide. These individuals cannot own or operate the provider agency providing services to their minor children/step-children or spouse. Services may be provided by relatives or friends (except for legally responsible relatives/persons as noted above). Direct Care Staff must have expertise, as appropriate, in the field in which the training is being provided. Services provided by relatives and friends may be covered if relatives or friends meet the qualifications for providers of care, there are strict controls to assure that payment is made to the relative or friends in return for specific services rendered, and there is justification as to why the relative or friend is the provider of care, e.g., lack of other qualified provider in remote areas. Medicaid payment may be made to qualified parents of minor children to spouses for extraordinary services requiring specialized skills (e.g., skilled nursing, physical therapy) which such people are not legally obligated to provide."

B. ASSURANCE THAT REQUIREMENTS ARE MET

The State assures that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services provided under the waiver.

C. PROVIDER REQUIREMENTS APPLICABLE TO EACH SERVICE

For each service for which standards other than, or in addition to State licensure or certification must be met by providers, the applicable educational, professional, or other standards for service provision or for service providers are attached to this Appendix, tabbed and labeled with the name of the service(s) to which they apply.

When the qualifications of providers are set forth in State or Federal law or regulation, it is not necessary to provide copies of the applicable documents. However, the documents must be on file with the State Medicaid agency, and the licensure and certification chart at the head of this Appendix must contain the precise citation indicating where the standards may be found.

D. FREEDOM OF CHOICE

The State assures that each individual found eligible for the waiver will be given free choice of all qualified providers of each service included in his or her written plan of care.

**APPENDIX B-3**

KEYS AMENDMENT STANDARDS FOR BOARD AND CARE FACILITIES

KEYS AMENDMENT ASSURANCE:

The State assures that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

APPLICABILITY OF KEYS AMENDMENT STANDARDS:

Check one:

___ Home and community-base services will not be provided in facilities covered by section 1616(e) of the Social Security Act. Therefore, no standards are provided.

__**X**__ A copy of the standards applicable to each type of facility identified above is maintained by the Medicaid agency.

## APPENDIX C - Eligibility and Post-Eligibility

### Appendix C-1: Eligibility

MEDICAID ELIGIBILITY GROUPS SERVED

Individuals receiving services under this waiver are eligible under the following eligibility group(s) in your State plan. The State will apply all applicable FFP limits under the plan. **(Check all that apply.)**

1.____ Low income families with children as described in section 1931 of the Social Security Act.

2. **X** SSI recipients (SSI Criteria States and 1634 States).

3.____ Aged, blind or disabled in 209(b) States who are eligible under ə 435.121 (aged, blind or disabled who meet requirements that are more restrictive than those of the SSI program).

4. **X** Optional State supplement recipients

5. **X** Optional categorically needy aged and disabled who have income at (Check one):

a. **X** 100% of the Federal poverty level (FPL)

b. ___% Percent of FPL which is lower than 100%.

6. **X** The special home and community-based waiver group under 42 CFR 435.217 (Individuals who would be eligible for Medicaid if they were in an institution, who have been determined to need home and community-based services in order to remain in the community, and who are covered under the terms of this waiver).

Spousal impoverishment rules are used in determining eligibility for the special home and community-based waiver group at 42 CFR 435.217.

**X** A. Yes ___B. No

Check one:

a.___ The waiver covers all individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community; or

b. **X** Only the following groups of individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community are included in this waiver: (check

all that apply):

(1)___ A special income level equal to:

____ 300% of the SSI Federal benefit (FBR)

___% of FBR, which is lower than 300% (42 CFR 435.236)

$___ which is lower than 300%

(2)___ Aged, blind and disabled who meet requirements that are more restrictive than those of the SSI program. (42 CFR 435.121)

(3)___ Medically needy without spend-down in States which also provide Medicaid to recipients of SSI. (42 CFR 435.320, 435.322, and 435,324.)

(4)___ Medically needy without spend-down in 209(b) States. (42 CFR 435.330)

(5) **X** Aged and disabled who have income at:

a. **X** 100% of the FPL

b.___% which is lower than 100%.

(6)___ Other (Include statutory reference only to reflect additional groups included under the State plan.)

7. **X** Medically needy (42 CFR 435.320, 435.322, 435.324 and 435.330)

8. **X** Other (Include only statutory reference to reflect additional groups under your plan that you wish to include under this waiver.) Foster children or children receiving adoption assistance.

**Appendix C-2: Post-Eligibility**

GENERAL INSTRUCTIONS

ALL Home and Community-Based waiver recipients found eligible under 435.217 are subject to post-eligibility calculations.

Eligibility and post-eligibility are two separate processes with two separate calculations. Eligibility determines whether a person may be served on the waiver. Post-eligibility determines the amount (if any) by which Medicaid reduces its payment for services furnished to a particular individual. By doing

so, post-eligibility determines the amount (if any) for which an individual is liable to pay for the cost of waiver services.

An eligibility determination (and periodic re-determination) must be made for each person served on the waiver.

Post-eligibility calculations are made ONLY for persons found eligible under ∋435.217.

Post-eligibility determinations must be made for all groups of individuals who would be eligible for Medicaid if they were in a medical institution and need home and community-based services in order to remain in the community (∋435.217). For individuals whose eligibility is not determined under the spousal rules (∋1924 of the Social Security Act), the State must use the regular post-eligibility rules at 435.726 and 435.735. However, for persons found eligible for Medicaid using the spousal impoverishment rules, the State has two options concerning the application of post-eligibility rules:

OPTION 1: The State may use the post-eligibility (PE) rules under 42 CFR ∋435.726 and ∋435.735 just as it does for other individuals found eligible under ∋435.217 or;

OPTION 2: It may use the spousal post-eligibility rules under ∋1924.

REGULAR POST-ELIGIBILITY RULES--435.726 and 435.735

- The State must provide an amount for the maintenance needs of the individual. This amount must be based upon a reasonable assessment of the individual's needs in the community.

- If the individual is living with his or her spouse, or if the individual is living in the community and the spouse is living at home, the State must protect an additional amount for the spouse's maintenance. This amount is limited by the highest appropriate income standard for cash assistance, or the medically needy standard. The State may choose which standard to apply.

- If the individual's spouse is not living in the individual's home, no maintenance amount is protected for that spouse's needs.

- If other family members are living with the individual, an additional amount is protected for their needs. This amount is limited by the AFDC need standard for a family of the same size or by the appropriate medically needy standard for a family of the same size. The State may choose which standard to apply.

SPOUSAL POST-ELIGIBILITY--ə1924

When a person who is eligible as a member of a 42 CFR 435.217 group has a community spouse, the State may treat the individual as if he or she is institutionalized and apply the post-eligibility rules of ə1924 of the Act (protection against spousal impoverishment) instead of the post-eligibility rules under 42 CFR 435.726 and 435.735. The ə1924 post-eligibility rules provide for a more generous community spouse and family allowance than the rules under 42 CFR 435.726 and 435.735. Spousal impoverishment post-eligibility rules can only be used if the State is using spousal impoverishment eligibility rules.

The spousal protection rules also provide for protecting a personal needs allowance (PNA) "described in ə1902(q)(1)" for the needs of the institutionalized individual. This is an allowance which is reasonable in amount for clothing and other personal needs of the individual . . . while in an institution." For institutionalized individuals this amount could be as low as $30 per month. Unlike institutionalized individuals whose room and board are covered by Medicaid, the personal needs of the home and community-based services recipient must include a reasonable amount for food and shelter as well as for clothing. The $30 PNA is not a sufficient amount for these needs when the individual is living in the community.

Therefore, States which elect to treat home and community-based services waiver participants with community spouses under the ə1924 spousal impoverishment post-eligibility rules must use as the personal needs allowance either the maintenance amount which the State has elected under 42 CFR 435.726 or 42 CFR 435.735, or an amount that the State can demonstrate is a reasonable amount to cover the individuals maintenance needs in the community.

## REGULAR POST ELIGIBILITY

1. **X** **SSI State.** The State is using the post-eligibility rules at 42 CFR 435.726. Payments for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipient's income.

   A. ə 435.726--States which do not use more restrictive eligibility requirements than SSI.

      a. Allowances for the needs of the

         1. individual: (Check one):

            A.___ The following standard included under the State plan (check one):

(1)___ SSI

(2)___ Medically needy

(3)___ The special income level for the institutionalized

(4)___ The following percent of the Federal poverty level):___%

(5)___ Other (specify):

_____

B.___ The following dollar amount: $_____*

* If this amount changes, this item will be revised.

C.__**X**__ The following formula is used to determine the needs allowance:
**100% of the FPL**

**Note:** If the amount protected for waiver recipients in item 1. is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under 42 CFR 435.217, **enter NA in items 2. and 3**. following.

2. spouse only (check one):

A.___ SSI standard

B.___ Optional State supplement standard

C.___ Medically needy income standard

D.___ The following dollar amount: $_____*

* If this amount changes, this item will be revised.

E.___ The following percentage of the following standard that is not greater than the standards above: ____% of ____standard.

F.___ The amount is determined using the following formula:

G.__**X**__ Not applicable (N/A)

3. Family (check one):

A.___ AFDC need standard

B.___ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the States approved AFDC plan or the medically income standard established under 435.811 for a family of the same size.

C.___ The following dollar amount: $____*

*If this amount changes, this item will be revised.

D.___ The following percentage of the following standard that is not greater than the standards above: %___ of ____ standard.

E.___ The amount is determined using the following formula:

F.___ Other

G.__**X**__ Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.726.

POST-ELIGIBILITY

## REGULAR POST ELIGIBILITY

1. (b)___ **209(b) State, a State that is using more restrictive eligibility requirements than SSI**. The State is using the post-eligibility rules at 42 435.735. Payments for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipient's income.

B. **42 CFR 435.735**--States **using more restrictive** requirements than SSI.

(a) Allowances for the needs of the

1. individual: (check one):

A.___ The following standard included under the State plan (check one):

(1)___ SSI

(2)___ Medically needy

(3)___ The special income level for the institutionalized

(4)___ The following percentage of the Federal poverty level: ___%

(5)___ Other (specify):

B.___ The following dollar amount: $_____*

* If this amount changes, this item will be revised.

C.___ The following formula is used to determine the amount:

**Note:** If the amount protected for waiver recipients in 1. is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under ∋435.217, **enter NA in items 2. and 3**. following.

2. spouse only (check one):

A.___ The following standard under 42 CFR 435.121:

B.___ The medically needy income standard _____;

C.___ The following dollar amount: $_____*

* If this amount changes, this item will be revised.

D.___ The following percentage of the following standard that is not greater than the standards above:_____% of

E.___ The following formula is used to determine the amount:

F.___ Not applicable (N/A)

3. family (check one):

A.___ AFDC need standard

B.___ Medically needy income standard

The amount specified below cannot exceed the higher of the

need standard for a family of the same size used to determine eligibility under the States approved AFDC plan or the medically income standard established under 435.811 for a family of the same size.

C.___ The following dollar amount: $_____*

* If this amount changes, this item will be revised.

D.___ The following percentage of the following standard that is not greater than the standards above: ____% of _____standard.

E.___ The following formula is used to determine the amount:

F.___ Other

G.___ Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.735.

**POST ELIGIBILITY**

**SPOUSAL POST ELIGIBILITY**

2.____ The State uses the post-eligibility rules of ∋1924(d) of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of home and community-based care if it determines the individual's eligibility under ∋1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(A) Allowance for personal needs of the individual: (check one)

(a)___ SSI Standard

(b)___ Medically Needy Standard

(c)___ The special income level for the institutionalized

(d)___ The following percent of the Federal poverty level: %

(e)___ The following dollar amount $___**

**If this amount changes, this item will be revised.

(f)___ The following formula is used to determine the needs allowance:

(g)___ Other (specify):

If this amount is different from the amount used for the individuals maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individuals maintenance needs in the community.

## APPENDIX D - ENTRANCE PROCEDURES AND REQUIREMENTS

**APPENDIX D-1:**

a. EVALUATION OF LEVEL OF CARE

The agency will provide for an evaluation (and periodic reevaluations) of the need for the level(s) of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future, but for the availability of home and community-based services.

b. QUALIFICATIONS OF INDIVIDUALS PERFORMING INITIAL EVALUATION

The educational/professional qualifications of persons performing initial evaluations of level of care for waiver participants are (Check all that apply):

___ Discharge planning team

__**X**__ Physician (M.D. or D.O.)

___ Registered Nurse, licensed in the State

___ Licensed Social Worker

___ Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)

__**X**__ Other (Specify): **Licensed Psychologist in the State of North Carolina**

**The following describes the process for evaluating waiver applicants to determine Level of Care:**
**Individuals referred for waiver funding will have their level of care assessed by a psychologist or physician as appropriate. The Local Management Entity (LME) will make the determination of Level of Care. The results of the determination will be made on the MR-2 form. (See attachment.)**

**The Behavioral Health Unit of DMA conducts quality assurance reviews that include a review of the application of eligibility criteria for individuals participating in the Waiver.**

**APPENDIX D-2:**

a. REEVALUATIONS OF LEVEL OF CARE

Reevaluations of the level of care required by the individual will take place (at a minimum) according to the following schedule (Specify):

___ Every 3 months

___ Every 6 months

___ Every 12 months

__X__ Other (Specify): **After initial evaluation, a re-evaluation will be completed annually during the consumer's birthday month.**

b. QUALIFICATIONS OF PERSONS PERFORMING REEVALUATIONS

Check one:

___ The educational/professional qualifications of person(s) performing reevaluations of level of care are the same as those for persons performing initial evaluations.

__X__ The educational/professional qualifications of persons performing reevaluations of level of care differ from those of persons performing initial evaluations. The following qualifications are met for individuals performing reevaluations of level of care (Specify):

___ Physician (M.D. or D.O.)

___ Registered Nurse, licensed in the State

___ Licensed Social Worker

__X__ Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a) **( In North Carolina this is called a Qualified Professional, as defined in G.S. 122C-3; 122C-25; 122C-26; 143-B-147.)**

___ Other (Specify):

c. PROCEDURES TO ENSURE TIMELY REEVALUATIONS

The State will employ the following procedures to ensure timely reevaluations of level of care (Check all that apply):

___ "Tickler" file

___ Edits in computer system

__X__ Component part of case management

___ Other (Specify):

**The state will employ the following procedures to ensure timely re-evaluations of Level of Care:**

**Annual re-evaluations will be completed by a Qualified Professional. This activity is an integral part of Targeted Case Management required activities, which are the responsibility of a Qualified Professional. Pending recommendations of level of care, the Lead Agency/Local Management Entity will complete the final determination of the continued authorization of Level of Care and Medical necessity.**

**If Level of Care of the individual is questioned during the re-evaluation, the individual will be referred back to the full evaluation process to verify the level of care and medical necessity.**

**The Behavioral Health Unit of DMA conducts quality assurance reviews that include a review of the application of eligibility criteria for individuals participating in the Waiver and will monitor level of care re-determination.**

**APPENDIX D-3**

a. MAINTENANCE OF RECORDS

1. Records of evaluations and reevaluations of level of care will be maintained in the following location(s) (Check all that apply):

___ By the Medicaid agency in its central office

___ By the Medicaid agency in district/local offices

___ By the agency designated in Appendix A as having primary authority for the daily operations of the waiver program

___ By the case managers

___ By the persons or agencies designated as responsible for the performance of evaluations and reevaluations

___ By service providers

__X__ Other (Specify): Local Management Entity (LME) or designated Lead Agency

2. Written documentation of all evaluations and reevaluations will be maintained as described in this Appendix for a minimum period of 3 years.

b. COPIES OF FORMS AND CRITERIA FOR EVALUATION / ASSESSMENT

A copy of the written assessment instrument(s) to be used in the evaluation and reevaluation of an individual's need for a level of care indicated in item 2 of this request is attached to this Appendix.

For persons diverted rather than deinstitutionalized, the State's evaluation process must provide for a more detailed description of their evaluation and screening procedures for individuals to ensure that waiver services will be limited to persons who would otherwise receive the level of care specified in item 2 of this request.

Check one:

___ The process for evaluating and screening diverted individuals is the same as that used for de-institutionalized persons.

**X** The process for evaluating and screening diverted individuals differs from that used for de-institutionalized persons. Attached is a description of the process used for evaluating and screening diverted individuals.

**Individuals referred for waiver funding who are being diverted from institutions will be evaluated and screened by either a physician or licensed psychologist. The evaluation of level of care will be made utilizing the MR-2 form, the same assessment instrument used for de-institutionalization persons. The Local Management Entity/Area Authority/County Program will make the determination of Level of Care of diverted individuals. The results of the determination will be documented on the MR-2.**

**APPENDIX D-4**

a. FREEDOM OF CHOICE AND FAIR HEARING

1. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, the individual or his or her legal representative will be:

   a. informed of any feasible alternatives under the waiver; and

   b. given the choice of either institutional or home and community-based services.

2. The agency will provide an opportunity for a fair hearing under 42 CFR Part 431, subpart E, to individuals who are not given the choice of home or community-based services as an alternative to the institutional care indicated in item 2 of this request or who are denied the service(s) of their choice, or the provider(s) of their choice.

3. The following are attached to this Appendix:

   a. A copy of the form(s) used to document freedom of choice and to offer a fair hearing;

   b. A description of the agency's procedure(s) for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver;

   c. A description of the State's procedures for allowing individuals to choose either

institutional or home and community-based services; and

d. A description of how the individual (or legal representative) is offered the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E.

## Fair Hearing Process

**Persons who are not given the choice of home and community-based services as an alternative to ICF-MR care or choose, but are not given, home and community based services as an alternative to ICF-MR care, or who are denied the service or provider of their choice are verbally notified of their right to a fair hearing. Each LME or designated Lead Agency will have in writing the appeal process at the local and state level, which contains, at a minimum:**

- **The right to a Fair Hearing;**
- **The method for obtaining a Fair Hearing;**
- **The rules that govern representation at Fair Hearings;**
- **The right to file grievances and appeals;**
- **The requirements and timeframes for filing a grievance or appeal;**
- **The availability of assistance in the filing process;**
- **The toll-free numbers that the individuals can use to file a Grievance and/or Appeal by phone;**
- **Rights, procedures and timeframes for voicing or filing Grievances and Appeals or recommending changes in policy and services.**

**Each participant will receive a copy of their rights at the time of eligibility screening for home and community based waiver services. In addition, each participant will be notified of their appeal rights when denial, reduction, or terminations of CAP-MR/DD services are made. Sample form attached.**

The requirements of the appeals process meet or exceed the requirements for a fair hearing established at 42 CFR Part 431, Subpart E.

b. FREEDOM OF CHOICE DOCUMENTATION

Specify where copies of this form are maintained: Case Manager, LME/Area Authority and designated Lead Agency.

# DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES HEARING REQUEST FORM

Please complete the information below to request an informal hearing with the State Division of Mental Health, Developmental Disabilities and Substance Abuse (DMH/DD/SAS). This form may be sent by hand, mail or fax.

*Send to: DMH/DD/SAS Appeal Hearing Office, c/o Stuart Berde, Ph.D. Mail Service Center 3009, Raleigh, NC 29699-3009; Fax (919) 733-4962; Telephone (919) 715-3197.*

Re: (Recipient's Name)
Legal Guardian:(Name)
MID#:
Area Program: (Name)

Dear Division Hearing Officer:

I would like the appeal to be held **(please check <u>one</u>):**

[ ] In my county [ ] In Raleigh, North Carolina

**Please check one below:**
While I am waiting for the DMH/DD/SAS hearing, I would like to take my appeal to an impartial local review. [ ] Yes [ ] No

Note: The impartial review is not required for you to have a State hearing.

**Please Provide the Information Below**

***What issue do you want this hearing to be about?***
Explain: _____

Person requesting the hearing _____

Relationship to recipient: _____

Address: _____

_____

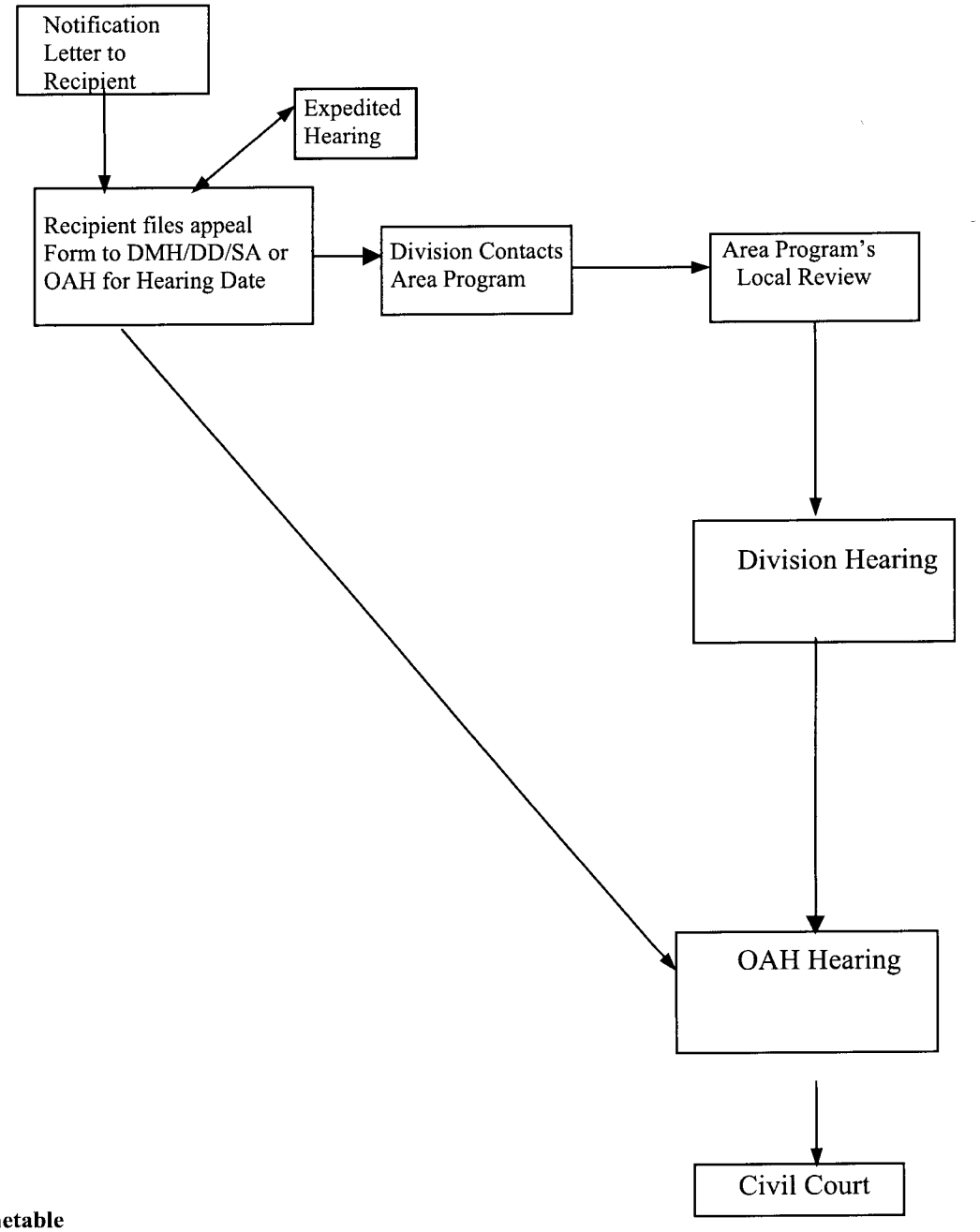
Telephone: _____

Signature: _____
(The signature of the consumer or legal guardian)

G.S. 108A-54, G.S. 150B-22, G.S. 108A-25(b), 42 CFR 431. 200 et. seq.

The following flow chart illustrates the appeal system available to Medicaid recipients.

## MEDICAID APPEAL FLOW CHART




**Timetable**

- Notification at least 11 days before date of a current service reduction, termination or suspension. Notification at the time a decision is made for denial of first time requests, a request for a service other than a current service and crisis facility situations.
- Expedited requests made to area program and decided within 2 working days.
- Request must be received by Division MH/DD/SAS on or before date when reduction, termination or suspension will occur for services to continue until a formal OAH hearing decision. Requests without continuation of benefits must be received by Division within 11 days of date on notification letter.

- Division hearing within 30 working days from receipt of hearing request.
- Division hearing decision 10 days after date of the hearing.
- OAH hearing within 90 working days of receipt of Petition for Contested Case Hearing; if form received on or before date of reduction, termination or suspension at Division or OAH, current services continue until OAH hearing decision.

North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services
Advocacy and Customer Services Section
(919) 715-3197 or 1-800-662-7030 TTY/Voice/Spanish Statewide

# MEDICAID NOTIFICATION LETTER REQUIREMENTS
# AREA AUTHORITY RESPONSIBILITIES

***The Notification Letter***

- Federal Law requires that Medicaid recipients receive written notification of their appeal rights (42 CFR 431 Sub-Part E).
- Area Authorities who authorize Medicaid services must send notification letters at legally required times.
- The Law specifies the content of the notification letters
- The Division MH/DD/SA has provided model letters for area authorities to use.
- Add your local contact information to the letterhead and the salutation.
- All letters and explanatory materials for area authorities and consumers are posted on the Customer Services and Community Rights Web Site at this address: www.dhhs.state.nc.us/mhddsas/consumeradvocacy
- The letters must be mailed.
- Certified mail is not required.
- Giving a recipient a copy of a letter does not eliminate the requirement to mail the letter.
- It is always advisable to continually apprise Medicaid recipients of the appeal process, in general, and the meaning of the notification letters.

*Advanced Notification*

- Federal Law requires that Medicaid recipients be notified in writing in advance of any decision to reduce, suspend, or terminate a Medicaid service.
- The law states that the notification letter must be sent at least 10 days (indicated by the date of the letter) before the intended date that a reduction, termination or suspension is to occur.
- Mail the letters the same day as the date of the notification letter so that a recipient has sufficient time to make an informed decision about whether or not to appeal.

*Exceptions to Advanced Notification*

- The letter shall be mailed no later than date of the area authority decision or the last date of the service in the following cases:
  - When the area program denies a Medicaid recipient's request for a different service from the one the recipient currently receives. (This also applies to a recipient applying for the first time to an area authority and the area authority has denied a Medicaid service.)
  - When a physician makes a clinical decision regarding crisis, short term hospitalization, or crisis facility care.
  - When the recipient is no longer eligible for Medicaid
  - When the recipient leaves the state.
  - When the recipient moves within the state and leaves no forwarding address.

Area Program Letterhead

Dear

We have made a clinical decision about your (name of Medicaid service). This letter describes the decision, the reasons for the decision, the services for which you do qualify, and your rights to disagree with our decision. The decision will not affect your Medicaid eligibility. Our clinical decision is marked below:

- ☐ We will reduce the (name of Medicaid service and current volume) to (new volume of named Medicaid service) on (date of change).
- ☐ We will suspend the (named Medicaid service) on (suspension date) and may resume the service at a later date, based on a reassessment.
- ☐ We will end the (named Medicaid service) on (date of change).

This is the reason why we made the above decision (Explain in full):

This is the Medicaid service that you will receive after the above date (Describe the new Medicaid service and volume. If none, say "none" and the reason):

If you accept our decision, then the rest of this letter does not apply to you.

If you disagree with our decision, you have the right to file an appeal. There are two legal ways to file an appeal:

1. You can appeal to the State Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS), with an option to appeal further to the State Office of Administrative Hearings (OAH). Complete and send in the attached appeal form, following the instructions on the form.
2. You can appeal directly to the State Office of Administrative Hearings (OAH) and by-pass the DMH/DD/SAS level. To file, call OAH at (919) 733-2698 to request a hearing form. When you receive the form, fill it out and send it to OAH.

You have the legal right to *continue* to receive the service in question until a decision is made, but to secure this right DMH/DD/SAS or OAH must receive your completed appeal form by (provide the date the service is to change or end). If you win the DMH/DD/SAS or OAH appeal, you will not be responsible for the costs of the service during the appeal period. But if you lose the appeal, you will be responsible for the costs of the service during this time.

You also have the right to an extended filing deadline. You must make sure that DMH/DD/SAS receives its appeal form, from you, within 11 days from the date of this letter or, if you so choose, OAH within 60 days from the date of this letter. If you win

the appeal, using these filing deadlines, the service in question will be restored to the original amount.

Finally, you can ask us about continuing the service in question at your own expense.

If you feel that by following any of the above steps, your condition will worsen or hurt a chance for improvement, you may appeal *immediately* to our office and we will alert DMH/DD/SAS.

Please address your questions to:
Stuart Berde State DMH/DD/SAS Advocacy and Client Rights Branch (919) 420-7927

(Area program contact person, name of Area Program and contact information)

Sincerely,

Area Program Contact Person

G.S. 108A-54, G.S. 150B-22, G.S. 108A-25(b), 42 CFR 431. 200 et. seq.

Area Program Letterhead

Dear

We have made a clinical decision about your service request. This letter describes the decision, the reasons for the decision, the services for which you do qualify, and your rights to disagree with our decision. The decision will not affect your Medicaid eligibility. Our clinical decision is marked below:

- ☐ We deny your request for (name of Medicaid service)

This is the reason why we made the above decision (Explain in full):

This is the service that for which you do qualify:

If you accept our decision, then the rest of this letter does not apply to you.

If you disagree with our decision, you have the right to file an appeal. There are two legal ways to file an appeal:

1. You can appeal to the State Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS), with an option to appeal further to the State Office of Administrative Hearings (OAH). Complete and send in the attached appeal form, following the instructions on the form.
2. You can appeal directly to the State Office of Administrative Hearings (OAH) and by-pass the DMH/DD/SAS level. To file, call OAH at (919) 733-2698 to request a hearing form. When you receive the form, fill it out and send it to OAH.

There is a filing deadline that you must meet. You must make sure that DMH/DD/SAS receives its appeal form, from you, within **11 days** from the date of this letter or, if you so choose, OAH within **60 days** from the date of this letter. If you win the appeal, we will authorize the requested service until you no longer need the service, based on a clinical assessment.

You can ask us about paying for the requested service at your expense, instead of filing an appeal.

If you feel that by following any of the above steps, your condition will worsen or hurt a chance for improvement, you may appeal *immediately* to our office and we will alert DMH/DD/SAS.

Please address your questions to:

Stuart Berde State DMH/DD/SAS Advocacy and Client Rights Branch (919) 420-7927

(Area program contact person, name of Area Program and contact information)

Sincerely,

Area Program Contact Person

G.S. 108A-54, G.S. 150B-22, G.S. 108A-25(b), 42 CFR 431.200 et. seq.

# MENTAL RETARDATION SERVICES

☐ PRIOR - APPROVAL ☐ ON-SITE ☐ UTILIZATION REVIEW

**PATIENT - INFORMATION - PA.**

| | | | | | |
|---|---|---|---|---|---|
| 1. PATIENT NAME (LAST, FIRST, MIDDLE) | | | 7. FACILITY | | 8. PROVIDER NUMBER |
| 2. BIRTH DATE (M/D/Y) | 3. SEX | 4. ADMISSION DATE (CURRENT LOCATION) | 9. TYPE OF FACILITY | 10. CURRENT LEVEL | 11. REC. LEVEL OF CARE |
| 5. COUNTY | MEDICAID NUMBER | | 12. PRIOR APPROVAL NUMBER | | 13. DATE APPROVED/DENIED |
| 6. RELATIVE | | | 14. ATTENDING PHYSICIAN | | |

## DIAGNOSIS

15. MENTAL RETARDATION

COGNITIVE LEVEL
- _____ MILD
- _____ MODERATE
- _____ SEVERE
- _____ PROFOUND

ADAPTIVE LEVEL
- _____ MILD
- _____ MODERATE
- _____ SEVERE
- _____ PROFOUND

16. CAUSE OF MENTAL RETARDATION _____

17. CURRENT MEDICAL DIAGNOSIS _____

| | | |
|---|---|---|
| 18. HEIGHT _____ WEIGHT _____ BP _____ | 19. BOWELS: _____ CONT. _____ INCONT. _____ | 20. URINARY: _____ CONT. _____ INCONT. _____ CATHETER |

## PATIENT EVALUATION

21. MEDICAL CONCERNS
- _____ OSTOMY CARE
- _____ ESOPHALGEAL REFLUX
- _____ HX OF DECUBITUS ULCER
- _____ CONTRACTURES
- _____ DIABETIC
- _____ HYPERTENSION
- _____ INSOMNIA
- _____ OTHER _____

22. FUNCTIONAL LIMITATIONS

VISION
- _____ NORMAL
- _____ IMPAIRED
- _____ BLIND

HEARING
- _____ NORMAL
- _____ DEAF
- _____ OTHER

SPEECH
- _____ NORMAL
- _____ NON-COMMUNICATIVE
- _____ GESTURES
- _____ ECHOLALIC

23. NUTRITION

DIET: _____

- _____ FEEDS INDEPENDENTLY
- _____ W/ASSISTANCE
- _____ PARENTERAL
- _____ TUBE

24. SKIN
- _____ NORMAL
- _____ OTHER _____

25. PERSONAL CARE

BATHING
- _____ INDEPENDENT
- _____ W/ASSIST.
- _____ TOTAL ASSIST.

DRESSING
- _____ INDEPENDENT
- _____ W/ASSIST.
- _____ TOTAL ASSIST.

26. AMBULATION
- _____ INDEPENDENT
- _____ AMB: W/ASSISTANCE
- _____ NON AMB/MOBILE
- _____ NON-AMB/NON MOBIL

27. BEHAVIORAL PROBLEM
- _____ VERBAL ABUSE
- _____ COMBATIVE
- _____ INAPPROPRIATE BEHAV.
- _____ WANDERER
- _____ RUN AWAY

INJURIOUS
- _____ PROPERTY
- _____ SELF
- _____ OTHERS

28. BEHAVIORAL CONTROL
- _____ BEHAVIORAL PLAN
  - ____ MODERATE/MILD
  - ____ SEVERE/PROFOUND
- _____ PSYCHOTROPIC MEDS
- _____ PHYSICAL RESTRAINTS
- _____ TIME OUT

29. SUPPORTIVE/PROTECTIVE DEVICES
- _____ NONE
- _____ WHEELCHAIR
- _____ WALKER/CRUTCHES/BRACES
- _____ HEARING AID
- _____ GLASSES
- _____ ADAPTIVE CLOTHING
- _____ ADAPT EATING UTENSILS
- _____ HELMET
- _____ SUPPORTIVE BELTS
- _____ BEDRAILS
- _____ LAP TRAYS
- _____ MODIFIED SHOES
- _____ MITTENS/SPLINTS
- _____ OTHER _____

## PLAN OF TREATMENT

30. CURRENT NEEDS
- _____ NURSING
  - RESTRAINTS_____
  - TYPE _____
  - SEIZURE CONTROL ____
- _____ PHYSICAL THERAPY
- _____ OCCUPATIONAL THERAPY
- _____ SPEECH THERAPY

31. LENGTH OF CARE DISCHARGE PLAN
- _____ OVER 180 DAYS
- _____ 60-180 DAYS
- _____ 30-60
- _____ OTHER _____

32. PHYSICIAN VISITS
- ____ 90 DAYS
- ____ OTHER _____

33. MEDICATIONS: DOSAGE, ROUTE, FREQUENCY.

34. HABILITATION PLAN GOALS/OBJECTIVES/ACTIVITIES _____

35. DIAGNOSTIC PROCEDURES _____

36. REHABILITATION POTENTIAL

37. REASON FOR LEVEL OF CARE/OTHER COMMENTS:

38. M.D. SIGNATURE _____ 39. DATE _____

## APPENDIX E - PLAN OF CARE

**APPENDIX E-1:**

1. PLAN OF CARE DEVELOPMENT

2. The following individuals are responsible for the preparation of the plans of care:

___ Registered nurse, licensed to practice in the State

___ Licensed practical or vocational nurse, acting within the scope of practice under State law

___ Physician (M.D. or D.O.) licensed to practice in the State

___ Social Worker (qualifications attached to this Appendix)

**X** Case Manager **(These individuals are Qualified Professionals or Associate Professionals working under the supervision of Qualified Professionals)**

___ Other (specify):

3. Copies of written plans of care will be maintained for a minimum period of 3 years. Specify each location where copies of the plans of care will be maintained.

___ At the Medicaid agency central office

___ At the Medicaid agency county/regional offices

**X** By case managers

___ By the agency specified in Appendix A

___ By consumers

**X** Other (specify): Local Management Entity (LME) or designated Lead Agency

4. The plan of care is the fundamental tool by which the State will ensure the health and welfare of the individuals served under this waiver. As such, it will be subject to periodic review and update. These reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the individual's disability. The minimum schedule under which these reviews will occur is:

___ Every 3 months

___ Every 6 months

**X** Every 12 months

___ Other (specify):

**APPENDIX E-2:**

a. MEDICAID AGENCY APPROVAL

The following is a description of the process by which the plan of care is made subject to the approval of the Medicaid agency: Attachment pages E-64

b. STATUTORY REQUIREMENTS AND COPY OF PLAN OF CARE

1. The plan of care will contain, service goals, specific service modalities/interventions with frequency and duration, responsibilities of each member of the treatment/habilitation team, a target date that reflects the time frame within which the goal(s), modalities/intervention and frequency/duration and responsibilities of each member of the treatment/habilitation team will be reviewed (a target date shall not exceed 12 months) and signature of staff, consumer/legally responsible person.

3. A copy of the plan of care form to be utilized in this waiver is attached to this Appendix. Attachment pages E1-E8.

4.

**A written plan of care will be developed for each individual under this waiver utilizing a family or person-centered planning process that reflects the needs and preferences of the individual and his or her family.**

**Family or person-centered planning is defined as a process, directed by the family or the individual with long-term care needs, intended to identify the strengths, capacities, preferences, needs and desired outcomes of the individual. The process includes people, freely chosen by the family or individual who are able to serve as important contributors. The family or person-centered planning process enables and assists the individual to identify and access a personalized mix of paid and non-paid services that will assist him/her to achieve personally defined outcomes in the most inclusive community setting. The individual identifies planning goals to achieve these personal outcomes in collaboration with those that the individual has identified, including medical and professional staff. The identified personally-defined outcomes and training, supports, therapies, treatments, and/or other services the individual is to receive to achieve those outcomes**

**become a part of the plan of care.**

**Person centered planning is a means for people with disabilities or long-term health care needs to exercise choice and responsibility in the development and implementation of their care plan. The planning process is directed by the individual and identifies strengths and capacities desires and support needs. A good person centered plan generates actions—positive steps that the person can take towards realizing a better and more complete life. Good plans also ensure that supports are delivered in a consistent, respectful manner and offer valuable insight into how to assess the quality of services being provided.**

**The person guides their care plan and chooses individuals to help them. Family members and friends are frequent contributors and the more traditional, professional service providers may also be included. Plans will incorporate varied supports, training, therapy, treatment and other services as needed to achieve the personal goals set by the individual. Plans draw upon diverse resources, mixing paid and natural supports to best meet the goals set.**

**Services, supports and treatment to individuals and families should be planned as well as implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning their life in the community. The system will include:**

- **Comprehensive information regarding the individual/family's preferences and personal goals, needs and abilities, health status as well as other available supports is gathered with the individual/family and used in the development of a person centered plan. Information and support is available to assist individuals and families to make informed choices regarding service options as well as providers.**
- **Information and support is available to assist participants to freely choose among qualified providers.**
- **Each individual's plan comprehensively addresses their identified need for supports, health care and other services in accordance with their expressed personal preferences and goals.**
- **Individuals and families have continuous access to assistance as needed to obtain and coordinate services and quickly address issues encountered in community living.**
- **All services and supports are provided in accordance with the individual or family's plan.**
- **Regular, systematic and objective methods, primarily individual or family feedback, are used to monitor the individual's well being, health status, and the effectiveness of supports and services in enabling the individual to achieve their personal goals.**
- **Significant changes in the individual or family's circumstances promptly trigger consideration of modifications to the person-centered plan.**

**The plan of care will describe the services and supports (regardless of funding source) to be furnished, their projected frequency, and type of provider who will furnish each service or support. (See attached Plan of Care form.)**

**NAME:** _____ **RECORD #:** _____

# _____'s Plan

**Plan Meeting Date:** _____

**For Plan Approver Only**
Plan Approved By: _____
Plan Approved Date: ___ / ___ / _____

| **Name** (As appears on Medicaid Card) | **Preferred Name** |
|---|---|
| **LME** | **Case Manager** |
| **Agency/Provider Name:** | |
| **Record Number** | **Date of Birth** |
| **Address** | **Phone** |
| **City, State, Zip** | **Medicaid County** |
| **Social Security Number** | **Medicaid ID#:** |
| **Gender**: ☐ **Female** ☐ **Male** | **Medicare/Insurance** |

**Race/Ethnicity:** White_ African Am__ Hispanic___
Native Am__ Asisan__ Other___

**TYPE**
☐ Initial Plan
☐ CNR

**CAP-MR/DD**
☐ At Risk for ICF/MR Placement
☐ Previously in an ICF-MR bed

☐ NC-SNAP Score _____

**RESIDENCY**
☐ Private home with natural family
☐ Individual Residence
☐ Supervised Living _____# of consumers
☐ Group Home _____# of consumers
☐ Child Foster Care
☐ AFL /Therapeutic Home
☐ ICF-MR
☐ Other (Specify) _____

**CONTACT PERSON**

☐
**Next of Kin/ Relationship**

☐ **Legally Responsible Person**

**Type**:

**Date of Action**:

**Name:**

**Address:**

**City/State/Zip**:

**Phone (home):**

**Phone (work):**

**PARTICIPANTS IN PLAN DEVELOPMENT**

NAME: _____ RECORD #: _____

# Medical Information

**Date Completed** _____

| | CODE | DIAGNOSIS | Indicate Primary Diagnosis with "P" |
|---|---|---|---|
| **AXIS I** | | | |
| | | | |
| **AXIS II** | | | |
| | | | |
| **AXIS III** | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| **AXIS IV** | | | |
| **AXIS V** | | | |

| MEDICATION | TARGET SYMPTOMS of THIS PERSON (Inc. Frequency, Intensity, Specificity) |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

| ASSESSMENTS (Including Medical and Dental) | LAST DATE | APPROX. DUE DATE |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**NAME:** _____ **RECORD #:** _____

| |
|---|
| **What has happened in life this past year (or if new plan, within the last few years)?**<br>**What goals have been met?** |

| |
|---|
| **What does want his/her life to be like? What is important? What are his/her goals?** |

**NAME:** _____ **RECORD #:** _____

**Who am I? What is important to me? What are my strengths and preferences?**

**What would I change about my life? What are problems or needs that I may have? What is not working in my life?**

**What will we accomplish with this plan?**

**NAME:** _____ **RECORD #:** _____

**What support do I need to maintain what is important to me in my life, and to change the things noted above in my life?**

**What natural supports are available to me? Family, friends, co-workers, etc.?**

**What community supports are available to me? Church, community organizations, civic groups?**

**In addition to the above, what other supports may I need including public funded supports?**

**Are there needs in my life related to health and safety, such as identified medical issues, need for behavior or crisis plan? If so, how will they be addressed?**

**What is the process for obtaining back-up staff in case of emergency?**

**NAME:** _____ **RECORD #:** _____

# Action Plan

This actions plan is developed to help _____ meet his/her goals through addressing what needs to change and needs to be maintained as identified on the previous pages.

| | **DESIRED PERSONAL, CLINICAL AND/OR FUNCTIONAL OUTCOME #** |
|---|---|
| **METHOD OF EVALUATION:** | |

| **WHAT** | **HOW** | **WHO'S RESPONSIBLE** | **BY WHEN** | **SERVICE AND FREQUENCY** |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

| | **DESIRED PERSONAL, CLINICAL AND/OR FUNCTIONAL OUTCOME #** |
|---|---|
| **METHOD OF EVALUATION:** | |

| **WHAT** | **HOW** | **WHO'S RESPONSIBLE** | **BY WHEN** | **SERVICE AND FREQUENCY** |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

(Repeat page as necessary)

**NAME:** _____ **RECORD #:** _____

# Case Management/Service Monitoring Plan

| TYPE | FREQUENCY / CONTACT SCHEDULE |
|---|---|
| **Face to Face:** Individual<br>Family / Guardian<br>Provider(s) | |
| **Collaterals:** Individual<br>Family / Guardian<br>Provider(s)<br>Education<br>Others (residential/ vocational, etc.) | |
| Service Observations / Visits<br>Review of Service Documentation<br>Review of Outcomes/Supports Strategies<br>Review of CM Indicator on Medicaid Card | |
| Other / Comments | |

**Attached are the following documents (check all that apply):**

- NC-SNAP (required for new and renewal) ☐
- Crisis Plan ☐
- Behavior Plan ☐
- Advanced Health/Mental Health Directive/DNR/PA ☐
- Justification for Equipment or Supplies ☐
- Individual Education Plan (IEP) ☐
- Other (Explain) ☐

**NAME:** _____ **RECORD #:** _____

# Signatures

The following signatures confirm the involvement of individuals in the development of this assessment and plan of care. All signatures indicate concurrence with the services/supports to be provided.

1) I confirm/concur my involvement in the development of this assessment and plan of care. My signatures indicate concurrence with the services/supports to be provided.
2) I understand that I have the choice of seeking care in an intermediate care facility for the mentally retarded instead of participating in the Community Alternatives Program for the Mentally Retarded / Developmentally Disabled (CAP/MR-DD). I choose to participate in CAP/MR-DD.
3) I understand that I have the choice of service providers and may change service providers at anytime by contacting my case manager

Individual: _____ Date: _____

Legally Responsible Person: _____ Date: _____

Case Manager:_____ Date:_____

_____ _____ Date:_____

_____ _____ Date:_____

_____ _____ Date:_____

**NAME:** _____ **RECORD #:** _____

# Plan Update/Revision

## Implementation Date: _____

What has happened in _____'s life (personal or clinical) to cause the need for revision?
*(Attach update NC-SNAP if there are changes)*

**Based on what is happening in my life, what is important to me now? What are my strengths and preferences?**

**Based on what is happening in my life, what needs to change now? What new problems or needs do I have? What is not working in my life?**

What do we need to know or do to support _____differently?

_____ **DESIRED PERSONAL, CLINICAL AND/OR FUNCTIONAL OUTCOME #**

_____

| WHAT | HOW | WHO'S RESPONSIBLE | BY WHEN | SERVICE & FREQUENCY |
|---|---|---|---|---|
| | | | | |
| | | | | |

**Required Signatures: The following confirms the involvement of the individual / guardian in the update of this plan including revision to the cost summary.**

**Individual:** _____ **Date:** _____

**Legally Responsible Person:** _____ **Date:** _____

**Case Manager** _____ **Date:** _____

_____ **Date:** _____

# CAP-MR COST SUMMARY---[DRAFT]

(1) Consumer Name: _____ (2) Unique ID: _____ (3) Consumer Record Number: _____

(4) Effective Date: _____ (5) Revision #: _____ (6) Revision Effective Date: _____ (7) LME Code: _____

(8) SNAP Score: _____

| (9) Service | (10) Service Code | (11) Provider Agency | (12) Frequency | (13) How Often | (14a) (14b) #Wks/#Mos or Yr | | (15a) FROM Date | (15b) TO Date | (16) Rate | (17) Monthly CAP-MR | (18) Annual CAP-MR |
|---|---|---|---|---|---|---|---|---|---|---|---|
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(19) TOTAL MONTHLY AND ANNUAL REIMBURSABLE COSTS BEFORE ADJUSTMENTS

(20) Comments:

## APPENDIX F - AUDIT TRAIL

a. DESCRIPTION OF PROCESS

1. As required by sections 1905(a) and 1902(a)(32) of the Social Security Act, payments will be made by the Medicaid agency directly to the providers of waiver and State plan services.

2. As required by section 1902(a)(27) of the Social Security Act, there will be a provider agreement between the Medicaid agency and each provider of services under the waiver.

3. Method of payments (check one):

____ Payments for all waiver and other State plan services will be made through an approved Medicaid Management Information System (MMIS).

__X__ Payments for some, but not all, waiver and State plan services will be made through an approved MMIS. A description of the process by which the State will maintain an audit trail for all State and Federal funds expended, and under which payments will be made to providers is attached to this Appendix.

____ Payment for waiver services will not be made through an approved MMIS. A description of the process by which payments are made is attached to this Appendix, with a description of the process by which the State will maintain an audit trail for all State and Federal funds expended.

____ Other (Describe in detail):

b. BILLING AND PROCESS AND RECORDS RETENTION

1. Attached is a description of the billing process. This includes a description of the mechanism in place to assure that all claims for payment of waiver services are made only:

a. When the individual was eligible for Medicaid waiver payment on the date of service;

b. When the service was included in the approved plan of care;

c. In the case of supported employment, prevocational or educational services included as part of habilitation services, when the individual was eligible to receive the services and the services were not available to the individual through a program funded under section 602(16) or (17) of the Individuals with Disabilities Education Act (P.L. 94-142) or section 110 of the Rehabilitation Act of 1973.

__X__ Yes

____ No. These services are not included in this waiver.

2. The following is a description of all records maintained in connection with an audit trail. Check one:

____ All claims are processed through an approved MMIS.

__X__ MMIS is not used to process all claims. Attached is a description of records maintained with an indication of where they are to be found.

3. Records documenting the audit trail will be maintained by the Medicaid agency, the agency specified in Appendix A (if applicable), and providers of waiver services for a minimum period of 3 years.

c. PAYMENT ARRANGEMENTS

1. Check all that apply:

__X__ The Medicaid agency will make payments directly to providers of waiver services.

__X__ The Medicaid agency will pay providers through the same fiscal agent used in the rest of the Medicaid program.

____ The Medicaid agency will pay providers through the use of a limited fiscal agent who functions only to pay waiver claims.

____ Providers may *voluntarily* reassign their right to direct payments to the following governmental agencies (specify):

Providers who choose not to voluntarily reassign their right to direct payments will not be required to do so. Direct payments will be made using the following method:

2. Interagency agreement(s) reflecting the above arrangements are on file at the Medicaid agency.